INDONESIA – INVESTING IN NUTRITION AND EARLY YEARS - 2

(INEY - 2)

PROGRAM-FOR-RESULTS (PforR)

ENVIRONMENTAL AND SOCIAL SYSTEMS ASSESSMENT (ESSA) REPORT

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PREPARED BY THE WORLD BANK

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1. INTRODUCTION

1.1 Background and Objective

1. The ESSA process is guided by the key policy elements as established by the Bank Policy Program for Results (PforR) Financing (November 2017) as they applicable to the assessment of the Government of Indonesia (GOI) systems and the relevant ministries/agencies' capacity to plan and implement effective measures for managing environmental and social risks and impacts. The key policy elements with regards to environmental and social management systems of the Bank Policy are:

   a. promote environmental and social sustainability in the PforR Program design; avoid, minimize or mitigate adverse impacts, and promote informed decision-making relating to the PforR Program's environmental and social impacts;

   b. avoid, minimize or mitigate adverse impacts on natural habitats and physical cultural resources resulting from the PforR Program;

   c. protect public and worker safety against the potential risks associated with: (i) construction and/or operations of facilities or other operational practices under the PforR Program; (ii) exposure to toxic chemicals, hazardous waste, and other dangerous materials under the PforR Program; and (iii) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards;

   d. manage land acquisition and loss of access to natural resources in a way that avoids or minimizes displacement, and assist the affected people in improving, or at the minimum restoring, their livelihoods and living standards;

   e. give due consideration to the cultural appropriateness of, and equitable access to, PforR Program benefits, giving special attention to the rights and interests of the Indigenous Peoples and to the needs or concerns of vulnerable groups; and

   f. avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.

2. The objectives of the ESSA are to assess:

   a. potential environmental and social risks and benefits;

   b. environmental and social systems that apply to the program;

   c. implementation experience and capacity;

   d. whether system and performance are consistent with the key principles of the Bank Policy; and

   e. steps to be taken to improve the scope of system or capacity.

1.2 Approach to the ESSA

3. The ESSA process focused on the systems to address the following effects identified through screening:

   a. Environmental considerations: segregation, storage, collection, and treatment of medical waste including pharmaceutical waste (expired/damaged/unused vaccines, vaccine vials, used syringes); access to clean water supply (quality and quantity); community behavior in relation with sanitation and access to sanitation facilities, e.g., toilet and septic tank, domestic solid waste and wastewater treatment; and government and Primary Health Care (PHC)s influence toward behavior and access to sanitation facilities.

   b. Social considerations: participation by vulnerable groups in village-level decision making; program benefits for remote communities and Indigenous Peoples; gender-related limitation in decision-making power and control over resources at the household level; accessibility

on education and health service delivery; inclusiveness or specificity of the context delivery (i.e. take into account literacy, including health literacy, language, gender, and cultural aspects); service agreement defining right and responsibilities (including labor health and safety aspects) of voluntary staff and cadres for the Program; availability of reliable grievance redress mechanism that reach out entire segment of community, including ones that have no access to internet or digital communication network.

4. The ESSA was developed through a review of relevant information on the environmental and social systems underpinning the program, as well as engagement and field visits to understand the operationalization of those systems, including the infrastructure in place to support and the capacity to implement them. The ESSA process thus far has included:

   a. Information review of relevant environmental and social management procedures and standards that are applicable to the Program:

      - Environment: Government Regulation No. 22 of 2021 on Protection and Management of Environment ('GR 22/2021'); MoEF's Regulation No. 6 of 2021 on Procedures and Requirements of Hazardous Waste Management ('MoEF Reg. 6/2021'); MoEF's Regulation No. P.56/Menlhk-Setjen/2015 regarding Procedures and Technical Requirements for Hazardous and Toxic Waste Management from Health Service Facilities ('MoEF Reg. 56/2015'); Minister of Health (MoH)'s Regulation No. 18 of 2020 regarding Region-Based Medical Waste Management Practice for Public Health Facilities ('MoH Reg. 18/2020'); MoH's Regulation No. 3 of 2014 regarding Community-based Total Sanitation (*Sanitasi Total Berbasis Masyarakat*, or 'STBM') ('MoH 3/2014'); Act No. 17 of 2019 regarding 'Water Resource' ('Act 17/2019'); and Minister of Public Work and Housing (MoPWH)'s Regulation No. 37/PRT/M/2015 on 'Water and Water Resource Permit to Use' ('MoPWH Reg. 37/2015'); MoH's Regulation No. 27 of 2017 on Guidelines for Prevention and Control of Infection in Health Service Facility ('MoH 27/2017'); National standards (*Standar Nasional Indonesia,* or 'SNI') for sanitation facility establishment, e.g., SNI 2398:2017 on procedure for septic tank planning, SNI 6774:2008 on procurement of clean water, etc.
      - Social: Village Laws and guiding regulations (e.g. community participation, use of village funds, access to information). National instruments with provisions for Indigenous Peoples were also reviewed, along with existing grievance mechanism system at national and sub-national (districts) level and applicable regulations on community and workers health and safety. Understanding implementation of previous projects was also used to inform system capacity under the ESSA.

   b. Field assessments with the following summary:

      - Environment:
        - A site visit to Surabaya District in Jawa Timur Province was conducted on 16-17 February 2023 covering visits to village level PHC (Posyandu Prima[1]) of Kebonsari Village, Jambangan Sub-District, followed with meeting with Jambangan Sub-District Head and Surabaya City Mayor on stunting prevention action, resource, and data management. In the event, communication was made with Environmental Health Division Head of Surabaya City Health Agency regarding medical waste management at Surabaya City, particularly ones that generated from PHCs.
        - A site visit to Manggarai Timur District in Nusa Tenggara Timur was conducted on 21-22 February 2023 covering visits to districts and village level Primary Health Care

[1] Posyandu Prima is a pilot program from the MoH, where Puskesmas-supporting Posyandu (or Posyandu Pembantu, or 'Pustu') is upgraded by implementing certain service standards (e.g., service time) and digitalization (e.g., registration and medical recording). Posyandu Prima expands its service from originally focusing only for mother and child's health to wider range of patients such as teenager, adult, and elder patients. MoH is targeting upgrading 300,000 Pustu units to become Posyandu Primas.

(Puskesmas, Posyandu, and Poskesdes) of Peot Village and Bangka Kantar Village, Borong Sub-District, followed with meeting with Manggarai Timur Regent on existing stunting prevention program, available resources, sanitation programs, coordination between government stakeholders, waste management, sanitation program, etc. Further explanation about Puskesmas, Posyandu, please see Figure 2-1 and footnote 1.

- Social:
  - Same site visit to Manggarai Timur District in Nusa Tenggara Timur was conducted on 21-22 February 2023, with discussion focusing on stunting prevention program, labor agreement of the used health staffs and cadres including rights and responsibilities, trainings, health and safety aspect, public participation (especially for women), coordination between government stakeholders, grievance redress mechanism, etc. In addition, a meeting with religious leader of Manggarai Timur District was made to align stunting prevention program led by the government with the episcopal social program in the area.

c. Consultation for the ESSA as follow:

In addition to consultations with district, sub-district, and village level government officials, medical staffs, and religious leaders during the field assessments, consultations were conducted between 7 and 24 February 2023 through series of assessments meeting (offline and online) that involves multi-sectoral government authorities of Republic of Indonesia, led by the Secretariat of Vice President (SoVP) as Project Management Unit (PMU) of the Program, and participated by other ministries of agencies as Project Management Unit (PIU) whom include but not limited to, Ministry of Health (MoH), Ministry of Home Affairs (MoHA), Ministry of Finance (MoF), Ministry of Village (MoV), Ministry of Education, Culture, Research and Technology (MoEC), National Development Planning Agency (*Badan Perencanaan Pembangunan Nasional,* or 'BAPPENAS'), and National Population and Family Planning Agency (*Badan Kependudukan dan Keluarga Berencana Nasional*, or 'BKKBN'). Separately, consultations regarding institutional capacity on environment and social management were conducted with the Program's independent reviewer on 28 February 2023 and Program's representative in SoVP on 17 March 2023.

Consultation with MoEF (Ministry of Environment and Forestry) Directorate on Hazardous waste who is in charge for medical waste management at national level in cooperation with Bappenas (National Planning Agency) has also been undertaken on 24 March 2024 to gather more information related to the implementation of medical waste management regulations. Program Action Plan and commitment plan validation for the IPF component were also undertaken on 21 and 24 March 2023 with senior staff at SoVP to discuss feasibility of each action plan/recommendation. Further public consultation with a wider audience will be made before the appraisal including a validation workshop with relevant PIUs in mid-April 2023.

2. INEY PHASE 2 PFOR PROGRAM DESCRIPTION

2.1 Government Program

5. The most recent Indonesian Nutrition Status Survey (*Survey Status Gizi Indonesia, or* SSGI) 2022 and the National Health Survey (Riskesdas) 2018 indicates that 6.2 percent of children are born with low birthweight, and among children under the age of five, 17.1 percent are underweight, 21.6 percent are stunted, 7.7 percent are wasted, 3.5 percent are overweight, and 38.5 percent are anemic. Anemia—which when experienced during pregnancy can contribute to maternal mortality and low birthweight/small-for-gestational age births—is high in Indonesia: 48.9 percent of pregnant women and 32 percent of adolescent women are anemic. Despite the

significant improvements in stunting, the rates are still high, while the continued high rates of underweight children and anemic mothers indicates that this prioritized agenda will need sustained efforts in the near future.

6. Indonesia's Vice President initiated preparation of a National Strategy to Accelerate Stunting Prevention (S*tranas Stunting*) in August 2017 drawing on World Bank technical advice. The *Stranas Stunting* adopted a multi-sectoral convergence approach that commits 23 ministries to increase the impact of almost US$4 billion of government spending each year on nutrition-specific and nutrition-sensitive interventions and services. More recently, the President has added stunting reduction as one of 16 National Priority Projects and incorporated the *Stranas Stunting* targets and multi-sectoral convergence approach in the National Medium-Term Development Plan (RPJMN) for 2020-24. Implementation began in 2018, supported by the Investing in Nutrition and Early Years (INEY) Program, in 100 priority districts, expanded to an additional 60 districts in 2019, and added an additional 100 districts each year in 2020 and 2021, bringing the total to 360 districts in 2021.

7. A Presidential Regulation No. 72 of 2021 (*Peraturan Presiden*, or Perpres 72/2021) issued in August 2021 updated the *Stranas Stunting* and elevated its legal status. This newer Perpres enacted into law as Indonesia's whole-of-government approach to improve nutritional outcomes, reduce stunting, and accelerate human capital development. While adopting and updating many aspects of the *Stranas Stunting,* the Perpres 72/2021 solidified new implementation arrangements for the stunting reduction program, one important addition being the introduction of a new entity, the National Population and Family Planning Board (BKKBN) as the lead of the implementation team for stunting reduction. Among its other roles, BKKBN is entrusted with developing the national action plan which is known as National Action Plan for the Acceleration of Stunting Reduction (RAN PASTI) for Indonesia. BKKBN has also facilitated the introduction of Stunting Reduction Acceleration Teams at the provincial, district, and village levels. The first year of implementation of the Perpres 72/2021 has been informative for understanding the gaps and opportunities in the activities of the Stunting Reduction Acceleration Teams with previously introduced implementation modalities under the *Stranas Stunting*, such as the district convergence actions, village convergence scorecard, and work of the human development workers (HDW). With the Perpres 72/2021, *Stranas Stunting* implementation expanded nationwide in 2022, ahead of the previous plan to expand to all 514 districts by 2024.

8. To implement the programs stipulated in the Perpres 72/2021, Ministry of Health (MOH) have selected twelve (12) priority provinces which have high prevalence and number of stunting cases to accelerate stunting prevention. The 12 priority provinces consist of seven (7) provinces with the highest prevalence of stunting namely East Nusa Tenggara (NTT), West Sulawesi, Aceh, West Nusa Tenggara (NTB), Southeast Sulawesi, West Kalimantan and Central Sulawesi, while the additional five (5) provinces account for the highest number of stunted children under five.

9. The Perpres 72/2021 targets are to be achieved by implementing activities under the five pillars of the National Strategy for Acceleration of Stunting Reduction as follow:

Table 2-1 Overview of the Pillars of the National Strategy for Acceleration of Stunting Reduction based on Perpres 72/2021

Pillar	Scope and Rationale
Pillar 1: Improving leadership commitments and visions in ministries/agencies, provincial governments, district/city governments, and village governments;	Under this pillar, the President and Vice President will hold limited cabinet meetings; convene national Stunting Summits and encourage subnational leaders to hold local stunting summits to build top-to-bottom leadership; and hold ministers, governors, district heads, and mayors to account for meeting service delivery and stunting reduction targets. The annual Stunting Summits will also recognize districts that successfully reduce stunting, share and promote innovation, and showcase best practices.

Pillar	Scope and Rationale
Pillar 2: Improving behavior change communication and community empowerment;	The President and Vice President will lead a sustained public awareness campaign targeting policymakers, regional governments, community leaders, parents, Prospective brides and grooms, and the general public. The campaign will use a variety of outreach strategies, from mass media to home visits, and will also scale up and strengthen BCC programming.
Pillar 3: Improving the convergence of specific and sensitive interventions in ministries/agencies, provincial governments, district/city regional governments and village governments;	Indonesia has a highly decentralized system of government under which most service delivery is the responsibility of sub-national governments. Most nutrition-specific and nutrition-sensitive intervention are the responsibility of local governments. National government has the authority to set priorities which local governments should follow, and programs which they should implement, but there are limited mechanisms to enforce compliance with national priorities. The role of districts is even more important since the introduction of the Village Law in 2014. Substantial resources are now channelled from the central government and to the district and on to the village, but the quality of village expenditure is highly dependent on the quality of support and supervision which districts provide to villages. This is particularly important for nutrition interventions, many of which are delivered at the village level.
Pillar 4: Improving food and nutrition security at individual, family and community levels	This pillar focuses on food policy reforms and investments to enable improved access to good-quality and affordable nutritious food. It identifies the following four areas: food policy reforms, food fortification reforms, food contamination reforms, and food market investment policies.
Pillar 5: Strengthening and developing systems, data, information, research and innovations.	The President and Vice President will use a dashboard to monitor progress and identify, reward, and sanction the performance of line ministries, provinces, districts, and villages in accelerating stunting prevention. Perpres 72/2021 calls for strengthening national, district, and village data systems on service delivery, intervention targeting, and stunting. These improvements will also allow for faster and more robust learning and feedback loops and will facilitate course corrections during implementation.

10. Additionally, the Perpres 72/2021 also expands target groups for stunting prevention to adolescents as it considers that ensuring the health and nutritional status of both teenage boys and girls is important in preventing stunting. The high number of cases of anemia and other social issues (e.g., early marriage and pregnancy) especially for teenage girls, will have an impact on health outcomes including stunting. Therefore, education and health promotion activities regarding the importance of consuming balanced nutrition, iron tablets, and risks of early marriage/pregnancy need to be carried out on an ongoing basis. Educational/promotional activities not only targeted to teenagers, but also parents, schools, religious leaders, and society in general.

11. Simultaneously, Ministry of Health (MoH) offers complementary opportunities to strengthen the quality and delivery of primary health care (PHC) services that are at the core of accelerating stunting reduction. Indonesia's 237,000 Posyandus (village level PHC) and 10,300 Puskesmas (sub-district level PHC)[2] jointly aim to close gaps in geographic and financial access to quality health care. However, significant gaps are observed along the spatial and socioeconomic spectrum in terms of availability and quality of health care provision, exacerbated by the COVID-19 pandemic. The health transformation objective is to strengthen the health system's capacity to deliver high-quality, affordable, and accessible PHC services to all Indonesians, particularly those in remote and disadvantaged areas. The illustration of the health system in Indonesia is shown below in Figure 2.1.

[2] Posyandu, or integrated village-level service facilities are supported by a health worker and run by (volunteer) community health workers, or kader, that deliver essential health services, particularly related to child and maternal health. Puskesmas are sub-district level community health centers that provide primary care and population health management.

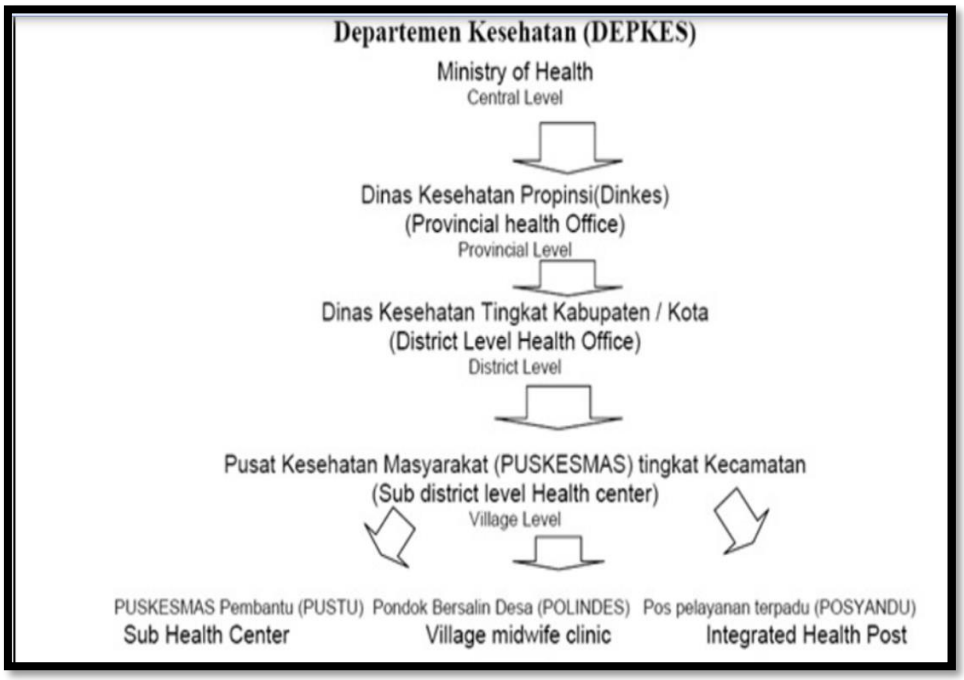

Figure 2-1 Ilustration of Health System in Indonesia

12. The PHC pillar of health transformation includes a thematic focus on stunting, in addition to PHC service delivery improvement, health promotion, tuberculosis, and immunization. In responding to the health and nutrition issues mentioned above, the Ministry of Health has stipulated eleven specific nutrition interventions. Those 11 essential nutrition specific intervention include screening for anemia for adolescent, Iron-Folic Acid Supplementation (IFAS) consumption for adolescent, antenatal check at least six times, IFAS consumption for pregnant women, complementary food with high animal protein for malnourished pregnant women, exclusive breastfeeding for at least 6 months, complementary foods rich in animal protein for age of 6-23 months, monitoring children under five growth and development through Posyandu activities, proper treatment for wasting and undernourished children under five, improving immunization coverage and expansion, and health and nutrition education/promotion. Through the convergence of these nutrition interventions at the sub-national level, Indonesia aims to strengthen primary health care and combat childhood stunting. The recruitment of approximately 75,000 human development workers has provided frontline support in identifying gaps in services while simultaneously drawing household members to obtain better health and nutrition services at the Posyandu and Puskesmas level.

2.2 PforR Scope

13. The World Bank and the Global Financing Facility (GFF), through the first phase of Investing in Nutrition and Early Years (INEY) Program, have been supporting the implementation of the government's program since 2018, first under *Stranas Stunting* and later under the Perpres 72/2021. The INEY Program development objective (PDO) is to increase simultaneous utilization of nutrition interventions by 1,000-day households in priority districts. INEY was designed to complement the existing World Bank portfolio at the time of approval (FY19) and focuses on: (i) addressing the management and system challenges that undermine convergence at each level of intervention delivery (central, district, and village); (ii) plugging critical gaps in the Government's mix of sector programming; and (iii) strengthening citizen engagement in the

frontline delivery and oversight of nutrition interventions. It aims to incentivize ten implementing agencies, hundreds of local governments, and tens of thousands of villages to collaborate to converge a multi-sectoral package of priority nutrition-specific and -sensitive interventions on priority households at the village level.

14. The proposed second phase PforR Program builds on the experience of the INEY's first phase and comprises an International Bank for Reconstruction and Development (IBRD) PforR loan in the amount of US$600 million combined with an IPF component in the amount of US$24 million financed by GFF (US$14 million) and the Gavi, the Global Vaccine Alliance (US$10 million). The second phase Program is in alignment with the Perpres 72/2021 national program for acceleration of stunting reduction and the primary health care transformation agenda. The design of the second phase is based on recommendations from the midterm review (MTR) of INEY whereby new financing is proposed to achieve the objectives for converged community level service delivery and sustain support to the GOI ambitious targets of achieving 14% stunting by 2024 and continue until 2030. The PforR will cover all program beneficiaries as outlined in Perpres 72/2021. The IBRD financing for INEY 2 will support: (a) Program scale up over four additional years (2023-27); (b) modification of results areas (RAs), DLIs, and targets to emphasize high impact interventions and learn from phase 1 Program implementation; and (c) new DLIs to target high impact, attainable aspects of the stunting reduction program, prioritized in the MTR. With many of the governance, coordination, and management concerns being substantially addressed in INEY's first phase, bandwidth is available from a Program management perspective to prioritize critical sectoral intervention support under the phase 2 financing, with a particular focus on essential health, nutrition, and immunization services delivered through the health sector[3].

15. The PforR will support following four RAs to be implemented in allover Indonesia:

RA1 - Strengthening leadership, commitment, and accountability for stunting reduction. Center-of-government oversight and coordination systems are critical to ensure that stunting remains politically salient, resources are managed to ensure program delivery, and there remains a consistent focus on outcomes. The DLIs under this RA sustain and deepen the elements of the whole-of-government approach implemented under INEY: (a) cascading political commitment, backed by accountability mechanisms, at all levels of government to implement Perpres 72/2021 according to respective responsibilities; (b) planning and budgeting systems that link resources to targets and outcomes; and (c) monitoring of implementation progress, evaluation of program performance, and dissemination of annual stunting data to resolve bottlenecks, drive better service delivery, and promote salience and accountability of the stunting reduction agenda across levels.

RA2 - Delivery and quality of specific and sensitive interventions. RA2 is designed to incentivize progress and improve the delivery of nutrition-specific and nutrition-sensitive interventions in Perpres 72/2021 that are high-impact and lack of support by existing operations and development partners. DLIs under this RA are designed to address gaps in (i) the implementation of high-quality early-learning program (PAUD) services (OR Implementation of Nutrition Action or Aksi Bergizi) and (ii) the strengthening of nutrition-specific interventions at national level through improvements in evidence & guidelines.

RA3 - Service delivery and convergence at district/city level for stunting reduction. Pillar 3 of Perpres 72/2021 focuses on strengthening regional and community level convergence, coordination, and consolidation. In INEY's first phase, all 514 district/city leaders signed memoranda of understanding to address stunting and implement eight Convergence Actions. Perpres 72/2021 proposes to continue the mobilization and accountability of district leaders by: engaging Regional Development Planning Agency (Bappeda), the local planning agency, to undertake analysis of key drivers of stunting in the local area and convene sector ministries to

[3] The Theory of Change of the PforR is provided in the Program Appraisal Document (PAD) - P180491

integrate stunting reduction in district plans, targets and budgets; implementing systems of results-based transfers to encourage continued progress; and to monitor and evaluate district performance.

RA4 - Service delivery and convergence at village & household level for stunting reduction. RA 4 delivery supports activities that will converge delivery of priority interventions on all target households in villages. The objectives of RA4 are to: (i) strengthen capacity of village Kader's to implement Perpres 72/2021 activities, including identifying households at risk of stunting and supporting nutrition intervention convergence; (ii) monitor changes in village convergence based on the consolidated beneficiary, Village Convergence Scorecard, and expenditure data; and (iii) strengthen Posyandus as the site of maternal and child health and nutrition service delivery. The RA will aim to incentivize villages to allocate additional budget from the Dana Desa to improve demand and supply for priority nutrition-specific and nutrition-sensitive interventions and increase the quality of and participation in community-based growth promotion and immunization activities.

16. The PforR Program comprises eleven disbursement linked indicators structured around four results areas as follow:

Table 2-2 Summary of INEY 2 DLIs[4]

Results Area		Disbursement-linked Indicators (DLI)	Responsible Ministries/Agencies
1	**Strengthening leadership, commitment and accountability for stunting reduction**	DLI 1: Accountability of district & provincial leaders to accelerate stunting prevention	SoVP, Bappenas, BKKBN & MoHA
		DLI 2: Results-Based and Climate-Responsive Nutrition Planning and Budgeting Systems	MoF & Bappenas
		DLI 3: Comprehensive MonEv system to enhance the stunting reduction program	Bappenas & MoH
2	**Delivery and quality of specific and sensitive interventions**	DLI 4: Implementation of high-quality PAUD services **OR** Scale up of aksi bergizi to provide support to adolescent nutrition in school	MoEC & MoV
		DLI 5: Strengthening nutrition-specific interventions at national level: improved evidence & guidelines	MoH, Bappenas
3	**Service delivery and convergence at district/city level for stunting reduction**	DLI 6: Provision of high-quality essential health and nutrition services in Puskesmas	MoH & MoHA
		DLI 7: Performance-based fiscal transfers to incentivize the district level to converge the acceleration of stunting reduction	Bappenas, MoF, MoHA & MoH
		DLI 8: Districts achieve good performance in converging the acceleration of stunting reduction	MoHA, MoF, Bappenas
4	**Service delivery and convergence at village & household level for stunting reduction**	DLI 9: Village kaders have skills and support to deliver quality essential health and nutrition services and coordinate service convergence	BKKBN, MoV, MoH & MoF
		DLI 10: Villages achieve good performance in converging the acceleration of stunting reduction	BKKBN, MoV, MoH
		DLI 11: Posyandu strengthening for provision of quality of essential health and nutrition services	MoH, MoHA, MoV

[4] Detailed description on each DLIs for respective RA is provided in Annex C.

2.3 Program Boundary

17. The program boundary is defined along the following dimensions: i) program focus; ii) focus area; iii) the implementing agency with overall responsibility, and iv) duration; and v) out-of-scope activity. These dimensions are defined as follows:

    i. Program focus: The second phase Program is in alignment with the Perpres 72/2021 national program for acceleration of stunting reduction and the PHC transformation agenda. The PforR will cover all program beneficiaries as outlined in Perpres 72/2021. The PforR will support modification of results areas (RAs), DLIs, and targets to emphasize high impact interventions and learn from phase 1 Program implementation; and new DLIs to target high impact, attainable aspects of the stunting reduction program, prioritized in the mid-term review (MTR).

    ii. Focus Area: The Program will be applied allover Indonesia.

    ii. Implementing agency with overall responsibility: The implementation of the national agenda to eliminate stunting (the government program) require a multisectoral approach, by involving SoVP as PMU and other ministries and government agencies as PIU as listed in **Error! Reference source not found.**.

    iii. Duration. The IBRD financing for INEY 2 will support Program scale up over four additional years (2023-27).

    iv. Out-of-scope activity: This Program does not include establishment of large infrastructure that require considerable land acquisition, natural habitats degradation, or landscape change such as construction of puskesmas, clinics, sanitary landfill facility, medical waste treatment facility, clean water filtering or domestic wastewater treatment facility at industrial/municipal-scale.

18. Alignment between GOI program and the PforR Program with is shown below.

Table 2-3 Proposed Scope of the Program

Item	GOI Program	Program Supported by the INEY-2 PforR
Title	National Strategy to Accelerate Stunting Prevention (Stranas Stunting), updated with provision under Perpres 72/2021	Investing in Nutrition and Early Years Second Phase Program (INEY-2)
Objective	To accelerate reducing stunting prevalence rate to 14 percent by 2024 with further reduction until 2030.	To enhance the delivery and convergence of services to accelerate the reduction of stunting in Indonesia.
Duration	2018-2030	2023-2027
Geographic coverage	Nationwide, with emphasis to 12 priority provinces	Nationwide
Results areas	• Pillar 1: Improving leadership commitments and visions in ministries/agencies, provincial governments, district/city governments, and village governments • Pillar 2: Improving behavior change communication and community empowerment; • Pillar 3: Improving the convergence of specific and sensitive interventions in ministries/agencies, provincial governments, district/city regional governments and village governments; • Pillar 4: Improving food and nutrition	• RA1 - Strengthening leadership, commitment and accountability for stunting reduction. • RA2 - Delivery and quality of specific and sensitive interventions. • RA3 - Service delivery and convergence at district/city level for stunting reduction. • RA4 - Service delivery and convergence at village & household level for stunting reduction.

Item	GOI Program	Program Supported by the INEY-2 PforR
	security at individual, family and community levels • Pillar 5: Strengthening and developing systems, data, information, research and innovations.	
Overall Financing (Annual)	US$ 6,593 million	US$ 198 million

3. ENVIRONMENTAL AND SOCIAL IMPACT ASSESSMENT

3.1 Exclusion of Significant E&S Impacts

19. Under the Bank Policy on Program-for-Results Financing, activities that are judged to have significant adverse impacts that are sensitive, diverse, or unprecedented on the environment and/or affected people are not eligible for the PforR financing and are excluded from the PforR Program.

20. By adopting the exclusion principles of the Bank Guidance[5], it was agreed that the INEY-2 PforR will apply the following exclusion criteria

- Significant conversion or degradation of critical natural habitats or critical cultural heritage sites;
- Air, water, or soil contamination leading to significant adverse impacts on the health or safety of individuals, communities, or ecosystems;
- Workplace conditions that expose workers to significant risks to health and personal safety;
- Land acquisition and/or resettlement of a scale or nature that will have significant adverse impacts on affected people, or the use of forced evictions;
- Large-scale changes in land use or access to land and/or natural resources (eg ecological resettlement);
- Adverse E&S impacts covering large geographical areas, including transboundary impacts, or global impacts such as greenhouse gas (GHG) emissions;
- Significant cumulative, induced, or indirect impacts;
- Activities that involve the use of forced or child labor;
- Marginalization of, discrimination against, or conflict within or among, social (including ethnic and racial) groups; and
- Activities that would (a) have adverse impacts on land and natural resources subject to traditional ownership or under customary use or occupation; (b) cause relocation of ethnic minority groups from land and natural resources that are subject to traditional ownership or under customary use or occupation; or (c) have significant impacts on ethnic minority cultural heritage.

21. In addition to the abovementioned project characteristic that are excluded from the PforR; considering the potential significant E&S risks of solid waste disposal facilities, medical waste treatment facilities, clean water purification facilities, and other large-scale infrastructure, following activities are excluded from the PforR scope: 1) construction or upgrading of primary health care facilities such as puskesmas, or medical waste treatment facility; 2) construction or upgrading of domestic waste disposal/treatment facilities (e.g., sanitary landfill facility; 3)

[5] Para.14 of Bank Guidance for Program-for-Results Financing Environmental and Social Systems Assessment (Sep. 18, 2020).

construction of large-scale clean water purification facility; 4) procurement of domestic waste collecting vehicles; 5) construction of large scale clean water distribution network and associated equipment such as pump house, etc. The list of activities under Government program (Perpres 72) that are aligned with INEY 2 are shown in Annex 5. From this annex the following Environmental and Social Risks and Effects are undertaken.

3.2 Environmental and Social Risks and Effects

3.2.1 Environmental and Social Benefits

22. The Program is anticipated to bring some benefits from the E&S standpoints, described as follow:

- Convergence at district/city level, including appointment of a dedicated focal agency handling the Program's E&S elements whom is authorized to coordinate with other relevant stakeholders in district/city level (such as sub-national health agencies, kaders at village level), would increase the opportunity of PHCs (particularly in the remote areas or without access to medical waste treatment/disposal facilities) to receive guidance and support in a more intensive and clearer manners on how they supposed to manage their own medical wastes so they could comply with the regulatory requirements. The agency may provide directions to those PHCs to handle their medical waste following procedures of the Appendix VI of the Minister of Environment and Forestry's Regulation No. P.56/Menlhk-Setjen/2015 regarding Procedures and Technical Requirements for Hazardous and Toxic Waste Management from Health Service Facilities ('MoEF Reg. 56/2015') also monitor and evaluate the actual implementation of this approach.
- Strengthened service delivery and convergence at district, village, and household levels could collaboratively improve accessibility of community members, including families with high-risk of stunting, for using appropriate sanitation facility provided in their household surroundings following technical specifications provided in the Minister of Health's Regulation No. 3 of 2014 ('MoH Reg. 3/2014') regarding Community-based Total Sanitation (*Sanitasi Total Berbasis Masyarakat*, or 'STBM'). This would include easier and more reliable access to individual or communal toilets, black water treatment unit (such as septic tank), and clean water distribution network and filtering apparatus.
- Strengthened service delivery and convergence at district, village, and household levels could also improve the way local health agency at district level partnering with PHCs in delivering STBM to the community as well as to monitor the impact and evaluate whether an adjustment of strategy/approach is required instead. To achieve this, the local health agency should be able to provide clear guidance and support continuously to the PHCs along the Program's lifetime.
- The Program could potentially provide an equal service for all community members, including indigenous people and vulnerable community, by also paying attention to cultural acceptability aspect.
- The Program could emphasize the aspect of rights of medical and volunteer resources in PHCs for obtaining appropriate trainings and instruments that are essential in order to protect their own health and safety while improving delivery of health services for the community.
- The Program could establish a better communication and coordination at district level that is exclusive among stakeholders, involving community members, medical staffs, cadres, government authorities, non-government organization (NGO), etc.
- The Program could set up an integrated mechanism to communicate and respond to grievances in accordance with internationally accepted standards.

3.2.2 Environmental and Social Risk and Effects

Environmental Risk and Effects

23. The overall potential environmental risk from the PforR components of INEY Phase 2 is considered as Moderate and is related to the implication of the increased numbers of Posyandu, supporting Posyandu strengthening, outreach and monitoring of zero dose immunization children, which generate medical waste from the vaccination (used syringe) and other nutrient interventions activities (expired vitamins, food waste etc.). Below are detailed rationales:

- Implementation of the Program in primary health care centers (such as pre-natal care and examination, birth support, child vaccination, supplementary nutrition supply for toddlers, etc.) are expected to contribute to the increment of medical waste, relative to the facilities' regular operational activities. In areas where PHCs could potentially generate a considerable amount of medical waste, such as in high-populated city like Surabaya, waste handling transporter and facilities are already accessible. For areas where access to licensed waste transporter and treatment facilities are very limited, a technical procedure in the Appendix VI of MoEF Regulation No. 56/2015 that allows medical waste to be handled safely can be applied. This procedure focuses on isolation and containment of medical waste within low permeability thick-clay (or for sharp objects layered with concrete) underground pit, which minimizes possible pathway for exposure against human and ecological receptors. It is noted however that such regulatory provisions have yet made familiarized to medical staffs and sanitarian at less developed area, leading to cases of prolonged storage of medical waste in inappropriate locations. This Program, on the other hand, should promote appointment of focal government agency that is responsible to ensure rightful implementation of such procedure by all primary heath care centers.
- Provisions of sanitation facilities at household scale in remote areas (including clean water pipelines, toilets, and septic tanks, dedicated domestic wastewater channel, nature-based water filtering device, and waste composting equipment) that are promoted by the Program, as part of the convergence actions, have positive effects and limited adverse impact on the environmental landscape. Most of the impacts are from construction activities that can be mitigated by the code of practices from public work agencies or the handbook of Good and Bad Infrastructure for the CDD-type construction works (PNPM, 2008). Establishment of such facilities have the potential to introduce positive effects on some environmental aspects, including pollution prevention and GHG emission reduction, as described below:
    - the provisions of separated domestic wastewater channels, toilets, and septic tanks are useful to control the release of fecal microorganisms into the natural media.;
    - the use of nature-based water filtering media reduces the possibility of disposal of chemical waste typically generated post treatment in water cleaning process, e.g., chlorine, hydrogen peroxide, etc.; and
    - the promotion of composting practice reduces emission from the burning of organic and domestic waste on each household yards in absence of municipal waste collector and nearby landfill facility system.

    To address the issue with the potential increase of medical waste generation from the Posyandu[6], current measures are in place to handle the medical waste aspect as stipulated

[6] MOH intends to increase the Posyandu numbers at village and urban wards (kelurahan) level but careful assessment of the activities at Posyandu reveals that Posyandu sessions are conducted on at least a monthly basis that will include growth monitoring, Family Planning, mental health counseling, general MCH care, guidance on the prevention of diarrhea, immunization and curative services. The immunization used will also vary (oral dose most of the time as compared injections). Outside of the Posyandu sessions, kaders are responsible for updating a register with names of pregnant women, postpartum and breastfeeding mothers, infants, and under-5 children); (2) updating the statistics describing Posyandu session utilization; (3) carrying out follow-

in the national regulations, and the increment of medical waste is not expected to overwhelm the existing system. However, there are incidents when medical waste is not properly collected, transported, and disposed of as per the regulations from the health care facilities other than Posyandu, such as Puskesmas or district hospital. This has gradually improved since 2017 (See Box 1). Measures will be included in the Program Action Plan to strengthen the awareness of the healthcare workers of the Puskemas/district hospital to transport their waste to the closest facilities available at provincial level. Whereas for health care facilities at a very remote area/lagging regions the socialization on the application of Annex 6 of PermenLH 56/2015 shall be intensified. In addition, an action plan similar to the one under I-Sphere and Covid PforR will also be developed, such as a regular coordination between MoH and MoEF and the formal appointment of focal point at SoVP to closely monitor this issue during program implementation (especially for remote locations and lagging regions in Indonesia) and to continuously remind TPK cadre and Posyandu staff of proper management of medical waste.

Box 1:

The Provision of Medical Waste Treatment Facilities

Since 2015 Indonesia through the MoEF (Ministry of Environment and Forestry) and Bappenas (National Planning Agency) started a breakthrough program for handling medical waste to respond to a nation-wide media coverage on illegal dumping of medical waste at a riverbank in Cirebon area (detik.com). This was due to a serious violation from the waste service provider and due to lack of facilities provided by the Government in handling medical waste. In 2017 Bappenas funded a project for MoEF to construct a medical waste facility by incinerating system that is properly designed and operated. The project is located at KIMA Industrial Estate in Makassar South Sulawesi. In 2020-2021 when pandemic hit, Bappenas decided to replicate the project by constructing one medical waste treatment facility for each province. Up to now, 2023, there are now 15 facilities across Indonesia that is full dedicated only to treat medical waste. In 2024 Bappenas targeted to construct another 10 facilities. The total target capacity is 26,880 tons/year. The first pilot project in KIMA with the capacity of 100 kg/hour is now started generating revenue and a set of provincial regulation as well as institutional arrangement (UPTD) had been established and this has become a model for other provinces. MoEF routinely monitor the performance of this facility including the environmental parameters. In Java Island itself there are now already 6 private companies who treat the medical waste certified by MoEF. The largest capacity to be built outside Java is 300 kg/hrs. The overall plan is to increase the capacity of treated hazardous waste to 26,880 tonnes per annum. As the key principle to medical waste treatment is 'proximity concept'; the surrounding provinces in other islands than Java that have no facilities can send their waste to the closest province. This will reduce the cost a lot as compared to send the same to Java Island. Whereas the medical waste handling for a very remote health care facilities (e.g., to reach the village we need to take a 4-hour boat trip) appendix VI of Permen 56/2015 is applied with permit issued by the local Health and Environment Agency. In cooperation with Environmental Health Directorate of Ministry of Health, the above information and available capacity and practice could become one of the program action plans to socialize these to Kaders at Posyandu, Health care workers at Puskemas, and Pustu (Puskesmas Pembantu).

Social Risk and Impact

24. The overall social risk of the PforR component of the INEY Phase 2 is rated Moderate, given the scale and complexity of the project, nationwide coverage. The INEY Phase 2 program is expected to contribute to addressing equity issues in nutrition intervention program distribution in the community. However, social risk remained, pertaining to equality in community access to the services and benefits of the program including across vulnerable groups and Indigenous People (if present in the targeted communities), potential challenges in engaging the disadvantages and hard-to-reach communities, cultural sensitivity of the Indigenous People, also the complexity of grievance mechanism that can be applied across provinces and villages.

25. Similar to the INEY Phase 1, the main social risks from the PforR components are related to the ability of individuals, households, and diverse community groups including the Indigenous Peoples and other vulnerable groups such as remote community and poor families, to get benefits from the stunting program and services in an accessible, safe, and inclusive manner.

up visits to houses of absent participants and participants who need further health education; and (4) attending community committee meetings. Source: https://chwcentral.org/indonesias-community-health-workers-kadersl/

Assessment undertaken during project preparation informed that communities in remote areas and vulnerable groups experience (and more prone to) challenges to access the educational and behavioral change communication, as well as in receiving nutrition specific interventions, particularly health services. It was observed that in the remote or traditional community, cultural barrier in receiving nutrition specific were still presence, while poor families with lesser education and limited access to advance health knowledge were still having low awareness on the urgency of pregnant mother and child nutrition in affecting stunting.

26. Such potential for inequality might create risk of conflict which stems from real or perceived differences in how the benefits of the program are distributed which makes the need for an effective grievance system important. As identified during the INEY Phase 1 implementation, there were challenges in the accessibility of community and stakeholder to a clear grievance mechanism (for receiving, tracking, and handling concerns, issues, challenges, inputs, and lessons learned) in relation to stunting reduction as well as program implementation. Based on the recent mission for the Phase 2 ESSA preparation, grievance handling practices among regions vary. A range of alternative mechanisms were observed although not all of them are formally recognized as a grievance mechanism. In less developed regions, health issues are communicated from person to person, via cadres or directly to the village government. Concerns/issues and challenges are also communicated during the quarterly multi-sectoral district government workshop meeting on health issue *(Lokakarya Mini Lintas Sektor Kesehatan)*. However, these mechanisms are not formally recognized as channels for grievances handling. As such, concerns/ issues shared through these channels are not captured/reported, properly tracked, and resolved. Meanwhile, in the more developed regions, mobile applications are utilized as a tool to monitor effectiveness of government's intervention program and to target the right beneficiaries. At national level, the effectiveness of Lapor!, a grievance handling mechanism which was proposed for the INEY Phase 1, varies between region, depending on the level of community access and familiarity with internet system, advanced electronic devices for communication and to social media. While it is considered to be effective in capturing concerns/issues/inputs from wider public/national level stakeholders, the latest INEY Phase 1 ISM identified challenges to properly record, track, report, and resolve grievances due to absence of specific role within the executing agency or staff in-charge for this channel. In addition, limited knowledge of broader community at village level regarding Lapor! was also reported. Alternative mechanisms, such as the use of social media (with the identified presence of TP2S in social media), issues and inputs/suggestions might be raised from public via Instagram, Facebook, LinkedIn, etc.; are also available. There is a need for improvement in managing the grievances received from all the channels to ensure appropriate response/ resolution is implemented.

27. Another risk is related to occupational health and safety (OHS) of workers involved in the operationalization of the program, particularly the community workers in Pustu/Posyandu (i.e., local cadres and volunteered staff). It is understood that generally, these community workers are not familiar with the health and safety standards and practices. Occupational health and safety risks may occur during their travel to sites for program implementation and during the use of health equipment when undertaking medical action (e.g., when assisting medical staffs in birth handling or if any interaction with pregnant women or child with communicable diseases). Limited access of these local cadres and volunteered staff to adequate occupational health and safety training program or facility may exacerbate the potential risks and impacts.

3.3 Contextual Risks

28. The contextual risk of the Program is considered Moderate. The Program will be implemented widely all over regions in Indonesia i, where some cultural sensitivities and ability to open access for distributing Program's services to remote sites will become essential factors to ensure the Program's objectives are achieved.

29. IP communities and other vulnerable groups are potentially living in the Program areas which makes these groups considered as potential subject of the Program implementation. Knowledge and skill on cultural-based approach are essential to be wielded by cadres and voluntary personnel in educating and ensuring participations of those groups in the Program. Equality of receiving services from PHCs or for having sanitation infrastructure established around the living area is likely going to be a challenge since many communities live in a geographically remote location from major cities.

30. Additionally, risks regarding enforcement of labor rights have to be considered, where it should promote cadres and volunteer personnel ('staf sukarela') to receive fair compensation and benefit for their efforts. Any contractual agreement between local agency with cadres and volunteer personnel should always guarantee protection of their rights, including the right to obtain adequate trainings and access to appropriate equipment while doing the works to ensure the health and safety of those personnel.

3.4 Institutional Capacity and Complexity Risks

31. Institutional capacity and complexity risk of the Program is considered Moderate. With the issuance of the Perpres 72/2021, adjustment on the INEY Phase 2 implementation arrangement will be made, as the Regulation substantially alters the implementation for the stunting reduction agenda beyond what was envisaged at the original INEY Phase 1 project design. The new regulation mandates BKKBN, as key technical lead of the national stunting prevention program, to be responsible for collecting field data and carrying out analytics, contributing to updated Convergence Action guidelines. The SoVP continues to play a central role, as the Chair of the Steering Committee. Bappenas is assigned to undertake the role of monitoring and evaluation for the program. The Coordinating Ministry for Human Development and Cultural Affairs (Kemenko PMK) is the Deputy Chair on implementation supervision and the MoHA is the Deputy Chair for oversight and monitoring of local governments. It is understood that the INEY Phase 2 will also add the Ministry of Health (MoH) to the implementation arrangements, which would be a valuable addition for the environment risk management, particularly related to medical waste issue. Previously under the INEY Phase 1, institutional support to the MoH at the central level has been deployed through SoVP. However, there is a need for substantial increase in the financing toward MoH objectives, requiring additional, intensified TA resources to support the agenda to be agreed with new leadership. MoH will be the lead agency tracking and conducting performance evaluation of national spending on priority nutrition interventions and priority districts implementation, and the implementation of behavior change communication activities.

32. Based on the Institutional Review, SoVP will resume its role that under the previous INEY-1 and the initial process of INEY-2 is in charge. Specifically on E&S aspects, SoVP currently has limited resource to appoint a dedicated focal point or specialist to ensure facilitation of E&S principles of the Bank, including through arranging a closer coordination between PHCs and relevant agencies in charge on E&S management (e.g., local health or environmental agencies).

3.5 Political and Reputational Risks

33. The overall political and reputational risks for the Program are considered Moderate. The Program is led by multi-sectoral ministries and agencies at both national and regional levels, which emphasizes convergence of various stakeholders at both levels to be able to obtain the best results of the Program. Separately, Indonesian government has determined to conduct a nation-wide presidential and legislative elections on 14 February 2024, followed with regional leader election on 27 November 2024. As consequences, changes in the leadership and organizational structure of relevant ministries and agencies at both national and regional levels are to be expected. In such situation, it is anticipated that the government's priorities would be then to follow the immediate political wills of respective elected leaders. Although it is unlikely that the new government regime is going to terminate or changes significantly the way the

Program is implemented, there is a possibility that the coordination scenario between ministries, agencies, and other stakeholders will need to be reconsolidated anticipating changes of bureaucratic officers within the government bodies that are highly likely to happen following the leader election. The new leaders and authorized officers should maintain the same commitments with what the institutions have agreed before the electoral events, and to prioritize the Program along their newly introduced agenda. Additionally, the new-appointed officers at government bodies (if they are) should be provided with sufficient information and knowledge on how the Program is being implemented so far, and what the expected goals and roadmap.

34. Aside of the abovementioned political concern, there is no considerable risk on reputational aspect coming out of the Program.

3.6 Overall Environmental and Social Risks Rating

35. The overall environmental and social risk rating for the Program consolidates the findings from the above assessment, with consideration of: 1) likely E&S effects as Moderate; 2) likely E&S contextual risks as Moderate; 3) likely institutional capacity and complexity risks as Moderate; and 4) likely political and reputational risks as Moderate.

36. The results show that the Program-supported activities tend to have moderate for both environmental and social impacts which revolves around the cultural appropriateness of the Program particularly for IP, equality to service delivery of the Program particularly for vulnerable groups and community in remote areas, and fulfillment of labor rights for non-staff personnel. The institutional capacity and complexity are Moderate, considering that this Program is implemented by various ministries, agencies, and regional government. SoVP currently may not have an available resource to become a focal specialist to ensure facilitation of E&S principles of the Bank, including through arranging a closer coordination between PHCs and relevant agencies in charge on E&S management (e.g., local health or environmental agencies). Additionally, the election of presidency, legislative, and regional leaders in 2024 is likely going to be followed up with certain changes in organizational structure and position of officers-in charge; causing a necessity for a follow-up coordination between institutions to guarantee prioritization of the Program post-electoral event.

4. ASSESSMENT OF GOI ENVIRONMENTAL AND SOCIAL CAPACITY AND MANAGEMENT SYSTEMS FOR INEY

37. The review of systems covers the current existing system to manage environmental and social risks associated with the PforR operations in response to the INEY Program. This section covers the review of the relevant policy, legal and regulatory frameworks. A summary of the institutional responsibilities is provided as they relate to environmental and social performance as part of the PforR activity implementation.

4.1 Relevant National Policy and Regulatory Framework

Overview

38. There have been quite significant regulatory changes related to stunting since the initial commencement of the INEY Phase 1. Specifically on stunting reduction, the President has added stunting reduction as one of 16 National Priority Projects and incorporated the National Strategy for Acceleration of Stunting Reduction (*Stranas* Stunting) targets and multi-sectoral convergence approach in the National Medium-Term Development Plan (RPJMN) for 2020-2024. Following the commencement of RPJMN, a Presidential Regulation (Perpres) No. 72/2021 was issued in August 2021. This new regulation enacted into law Indonesia's whole-of-government approach to improve nutritional outcomes, reduce stunting, and accelerate human capital development. Meanwhile although there is no one system specifically regulate

environmental and social performance, broader E&S regulatory framework has been frequently updated, including through the issuance of the Omnibus Law (UUCK or Job Creation Law).

39. The assessment has focused on the relevant provisions and key instruments that impact on the health and stunting program implementation, including community health service delivery at the household and village level; medical waste management; framework related to Indigenous People and attention to vulnerability; and complaints handling.

Medical Waste Management

40. The Government Regulation No. 22 of 2021 on Protection and Management of Environment ('GR 22/2021') considers that medical waste, consisted of clinical waste with infectious characteristics, expired pharmaceutical products or chemicals, medical/laboratory equipment contaminated with infectious waste, waste water treatment sludge from hospital and other medical/health facility, is categorized as hazardous waste. The regulation mandated general hazardous waste to be managed under provision of the GR 22/2021 itself with additional details provided in the MoEF's Regulation No. 6 of 2021 on Procedures and Requirements of Hazardous Waste Management ('MoEF Reg. 6/2021').

41. Requirements from the abovementioned regulations are harmonized with the Good International Industry Practice (GIIP), including the provisions on waste identification, reduction, segregation, storage, transport, disposal and occupational health and safety for waste handler – with all activities to managing medical (hazardous) waste, including to store, transport, treat or dispose, require valid permit/license from relevant agencies.

42. The country's approach in hazardous waste management is built upon the "cradle to grave" principle with a rigid manifest system to track the flow of waste from the generator to the disposal. As per 2020, manifest reporting is conducted through an online reporting application (namely "SIMPEL" or "SIRAJA") directly by hazardous waste producer, transporter, or treatment facility/company or via barcoded manual manifest for later input into the online reporting system. This is system is established under the MoEF's Regulation No. P.4./MENLHK/SETJEN/KUM.1/1/2020 on Hazardous Waste Transportation ('MoEF Reg. 4/2021') with schematic process provided in Figure 4-1.

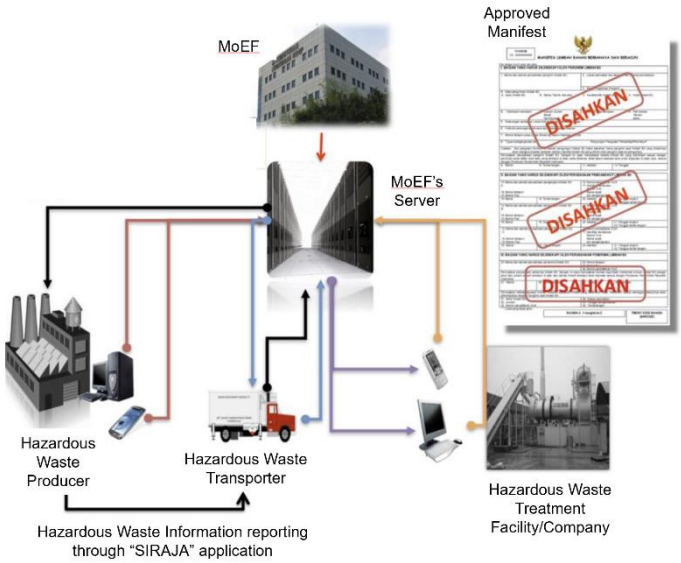

Figure 4-1 Electronic-Based- Hazardous Waste Recording and Reporting System in Indonesia[7]

[7] Translated from MoEF's website, 2020 (https://www.menlhk.go.id/site/single_post/3102/transformasi-digital-klhk-dengan-manifes-elektronik-limbah-b3)

43. Based on the Government Regulation No. 66 of 2014 on Environmental Health ('GR 66/2014'), waste management is part of the efforts to protect public health, in which waste management in health facilities, including clinics, laboratories and hospitals, must comply with the related Minister Regulations. As per regulatory requirements in Indonesia, medical waste ideally should be managed in accordance to the Minister of Health's Regulation No. 18 of 2020 regarding Region-Based Medical Waste Management Practice for Public Health Facilities ('MoH Reg. 18/2020') which in general mandating medical waste to be disinfected and appropriately segregated, manifest-recorded, stored temporarily at designated and licensed area, transported by licensed transporter, and finally destructed or landfilled in licensed facilities provided by the city/municipality government, or through agreement with certain private companies operating in the region.

44. In remote areas or communities where access to waste management collection and treatment facilities are not available/limited, such requirements are however not completely implementable. Healthcare facilities located in remote areas, and smaller healthcare facilities with limited amount of medical waste generation and budget for medical waste management often face challenges. For health facilities located far from any medical waste treatment facilities, when the amount of medical waste generated have not met the minimum amount for transport, the medical facilities will request extension of temporary storage of medical waste with the local Environmental Agency.

45. The GOI through MoEF and Bappenas have progressively increased numbers of medical waste treatment facilities in Indonesian starting from 2015 to overcome issues caused by uneven presence of licensed medical waste facilities in Indonesia. Currently 15 medical waste facilities have been established, with a projected addition of 10 facilities in 2024. Uneven distribution of licensed hazardous waste transporters, with 97 out of 140 licensed transporters located in Java should be considered as well as an aspect that needs to be improved. Using the 'proximity principles' the government is trying to establish one medical waste treatment facility per province so the cost and the risks from transportation of medical waste will be reduced. Based on the distribution and availability of medical waste processing facilities in Indonesia (Figure 4-2), it is evident that the waste processing facilities in the country are currently dominated by the use of incinerators.

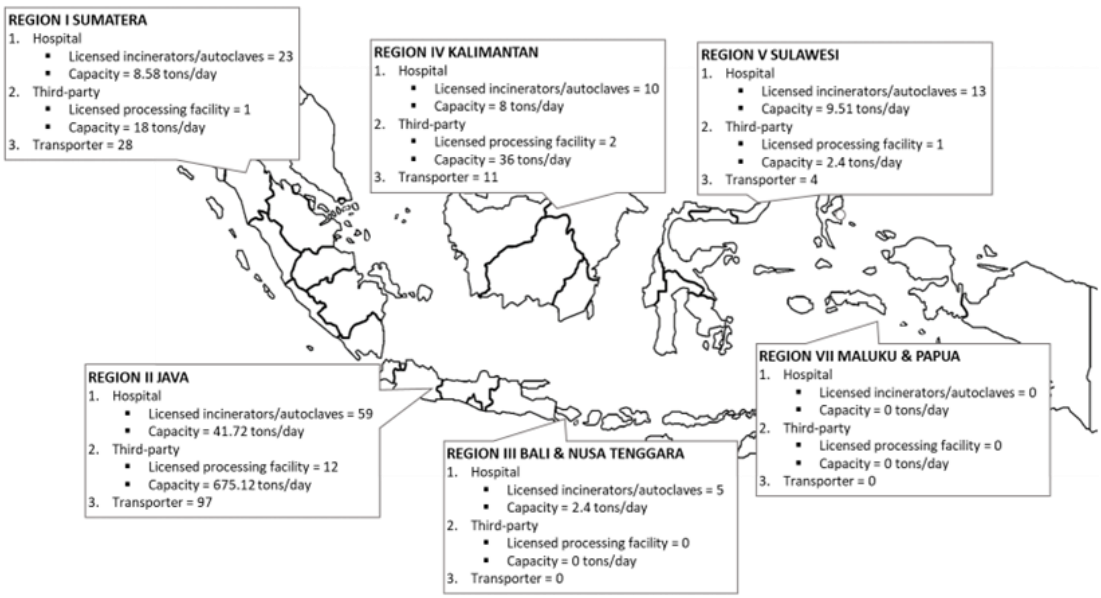

Figure 4-2 Distribution of medical waste processing facilities and transporters[8]

[8] MoH, 2023

46. Based on information collected from the MoEF, medical waste treatment facilities have been established in each of priority provinces with details provided in **Error! Reference source not found.**, however, during the assessment mission, it was noted that not all provinces has such facilities due to the issue of lack of priority for the governors/major , land availability and lack of awareness that this activities are revenue generating activities. Consequently, not all medical waste treatment facilities are available at each province as of now and the health center facilities might need to transport their waste to neighboring provinces which is not always located in reasonable transporting distance to the PHCs in addition to absence of appropriate (licensed) waste transporter service in many locations in remote areas. Indonesia has now 35 provinces.

Table 4-1 Medical Waste Treatment Facilities Capacity in 12 Priority Provinces[9]

No.	Province	Year of Establishment	Waste Treatment Capacity (kg/hour)
1	Sulawesi Selatan	2017	100
2	Aceh	2020	300
3	Sumatera Barat		300
4	NTB		300
5	NTT (Manggarai)		150
6	Kalimantan Selatan		150
7	Bangka Belitung	2021	200
8	Papua Barat		150
9	Sulawesi Barat		150
10	NTT (Sumba)		150
11	Jambi	2022	200
12	Kalimantan Utara		200

47. To meet the regulatory requirements, public health facilities located in remote areas or with minimum access to medical waste treatment/disposal facilities, could be directed and facilitated by district health agency to follow technical procedures regulated in a separate ministerial regulation, i.e., the Appendix VI of Minister of Environment and Forestry's Regulation No. P.56/Menlhk-Setjen/2015 regarding Procedures and Technical Requirements for Hazardous and Toxic Waste Management from Health Service Facilities ('MoEF Reg. 56/2015'). This regulation specifies procedure and technical requirement for such public health facilities to prevent or minimize exposure of pathological waste (e.g., body fluids-contaminated materials) and hazardous medical wastes (e.g., sharp objects, like needles or glass vials) generated from their operations by containing them in cemented brick or thick-clay layered dug holes in order to eliminate pathway of exposure to environmental or human receptors around the area. Existing regulations require healthcare facilities at provinces where there are no medical waste treatment facilities to maintain working contract with licensed transporter to transport the medical waste into nearby facilities. These regulations also include measures for environmental and workers' safety risks.

48. The MoH also makes it mandatory for all hospitals to obtain accreditation every three years. The primary healthcare accreditation, which include medical waste, are required for all Puskesmas and clinics and regulated in MOH Regulations No. 46/2015, and to be reassessed every three years for community health centers and hospitals. All parties involved in medical/hazardous waste management business (storage, transport, treatment, and disposal) will require special permits. The procedure to obtain such permit will follow Government

[9] MoH, 2023

Regulation No. 22/2021. The PforR need to ensure the system to monitor the medical waste generation and proper management of the medical waste are in place.

Sanitation Program

49. Framework of sanitation program in Indonesia is regulated in the Community-based Total Sanitation (*Sanitasi Total Berbasis Masyarakat*, or 'STBM') program, formalized under the MoH's Regulation No. 3 of 2014 ('MoH 3/2014'). This regulation provides basic sanitation principles to be conducted by and for the community, which includes implementation of hygiene behavior supported with procurement and maintenance of sanitation facilities such as (but not limited to) individual or communal toilets, black water treatment unit, such as septic tank; sanitary landfill facility; and clean water distribution network and filtering apparatus. This regulation mandates national and local government to establish specific strategy, technical approach, monitoring and evaluation methodologies for each community. Such strategy and approach should be disseminated to other stakeholders that interact directly with the community to initiate the program, e.g., medical personnel, cadres, volunteer personnel, donors, etc.; with continuous follow-up guidance and supports while they are being executed.

Community and worker health and safety

50. Indonesia has a comprehensive legislative framework regarding occupational health and safety (OHS) as well as community health and safety. Although main institutional responsibility of OHS management is under the Ministry of Manpower, however in relation to the Program, particularly the delivery of nutrition-specific and sensitive interventions (healthcare services and early years education providers) at village-level, responsibility of the workers' health and safety will be under each of the respective agency. These include the health and safety of midwives, nurses, cadres, and staff under Puskesmas and Posyandu (under the MoH), village facilitators (under the MoV/MoHA), also PAUD teachers under the Village Government coordination.

51. Applicable regulatory framework including the Law 1/1970 on Work Safety (Work Safety Law); Government Regulation (GR) 50/2012 on Implementation of Occupational Safety and Health System; and the Ministry of Manpower Regulation 5/2018 on Occupational Health and Safety in a Workplace Environment. In addition, relevant to the Program social risk on the community workers, applicable regulatory framework includes Law No. 36/2009 on Health and Law No. 4/1984 on Infectious Disease.

Attention to Indigenous People and Vulnerable Groups

52. To date, there is no statutory law that specifically addresses the matter yet. Bills have been introduced in 2014 and again in 2020 but have not been passed. An exception to this is the statutory recognition of the indigenous people in Papua under Law 21 of 2001 on Special Autonomy for Papua Province (as amended). For the rest of the country, the matter of indigenous people is addressed under various sectoral regulations. The second amendment to the 1945 Indonesian Constitution enshrines state recognition and respect for communities living by the customary law *(Adat)* and traditional value systems. Subsequent laws, such as the Basic Agrarian Law No. 5/1960 and the Forestry Law No. 41/1999 (with recent revision through Constitutional Court Ruling No.35/2013), also the Government Regulation (GR) No. 23/2021 on Management of Forestry and MoEF Regulation 9/2021 on Social Forestry Management provide recognition to the rights of *Adat* communities. However, these sectoral laws, including implementing presidential and ministerial regulations are focused on land and natural resources, as such they are not relevant to the ESSA. The recent enactment of the Village Law No.6/2014 also provides opportunities for *Adat* communities to strengthen their participation, including managing development that addresses their needs and aspirations through support from the village funds. However, guiding regulations with regards to *Adat* communities are still being developed and further facilitation support is currently being provided to some degree by MoV at the village level that corresponds to the needs of these communities.

53. Indonesian laws use various terms to refer to Indigenous Peoples which are interconnected with the regulation definition of vulnerable groups, including *masyarakat suku terasing* (isolated tribal communities/remote Indigenous communities), *masyarakat tertinggal* (lagging communities), *masyarakat terpencil* (remote communities), *masyarakat hukum adat* (customary law communities), and more simply masyarakat adat (communities governed by custom). These communities usually dependent on natural resources and have limited access to public facilities. Remote Indigenous Community is defined (Article 1 (2) of PR No. 186/2014), i.e., a group of people who are bound by geographical, economic, and/or socio-cultural unity, and are poor, live in a remote area, and/or are socio-economically vulnerable. They are to be empowered to be independent in meeting their basic needs such as food, clothing, housing, health, education, work, and/or social services (Articles 2 and 1(4) of Ministry of Social Affairs (MoSA) Regulation No. 12/2015). Implementation falls under the authority of MoSA in coordination with MoV, since program implementation at local (district and village) level would very much depend on the local government capacity. Another village regulation relevant to vulnerable groups is the MoV Regulation No. 19/2017 concerning prioritizing the use of village funds to improve the welfare of the village community and the quality of human life, which are essential for reduction of poverty. However, the legal framework is generally silent on specific differentiated measures to prevent exposing these groups to adverse impacts resulting from a project. Broader attention to project impacts on vulnerable groups is incorporated within the GoI's environmental impact assessment process as well as in the land acquisition for public interest, neither do not directly applicable for the Program.

54. The ESSA approach on Indigenous Peoples and vulnerable groups has been very much informed by the imperatives for social inclusion and Indigenous Peoples' ability to participate in program interventions in a meaningful and informed way. Therefore, the challenges foreseen with regards to Indigenous Peoples are not related to the legal framework pertaining to the rights of Indigenous Peoples, but more on technical aspects within the Program to ensure that the approach and engagement suits the needs and aspirations of these communities as well as the ability of the Program interventions to reach these communities, who may live in remote areas or still live in a nomadic and sedentary fashion, and therefore are hard to access. This will be further discussed in the section on findings.

Grievance Mechanism

55. There is no one system for receiving and addressing inputs, feedback or complaints, a range of existing mechanisms relevant to the Program are described below.

- National grievance channel: existing national complaint handling management system for all public services is called Lapor! and is managed under the Ministry of Administrative and Bureaucratic Reform (KemenPAN-RB). Under the INEY Phase 1 the system was agreed to be used by the Program for its grievance handling mechanism. The system has been integrated with most of government institutions, thus was expected to enable complaints resolution effectively. Stunting issue has been added into the Lapor! application menu. Feedback or concerns related to stunting program was expected to be channeled and handled by relevant ministries and institutions.
- Local (village and district) level: There is no single formalized channel for complaints handling at the village level. The INEY Phase 1 ESSA identified that the village community empowerment and development agency was the primary institutional unit for handling complaints related to village governance, however dominated by the misuse of village development funds, followed by village boundary disputes and misuse of authority by village officials. The current Program assessment identified potential roles of other agencies through their existing channels including MoV through their Village Facilitators; BKKBN through their Family Facilitators; and District government through the quarterly district government meeting for health sector. Complaints handling does not appear to form part of the responsibilities of any specific role/unit, and there is no specific assignment or

involvement in the actual dispute settlements, however with their local presence, capacity and regular coordination with the village stakeholders, their roles can be optimized to oversee and report issues related to Program.

- Puskesmas/Posyandu: There is no specific regulation on complaint handling for the delivery of Posyandu services. Should any serious adverse events such as illness post vaccination, common practice is to direct the complaint to Puskesmas staff or through midwives or directly to the District Health Agency.
- PAUD: Formal grievance handling at PAUD is not specifically regulated, however the preparation assessment of the Program identified that complaints related to PAUD were usually not related to the services provided for the delivery of holistic, integrated early childhood education and development (ECED), but rather the amount (or different amounts) of fees PAUD teachers/cadres received. Similar issue was identified in the INEY Phase 1 program. Grievances are handled on an ad-hoc basis.

Health services delivery at village level

56. The new Village Law No 6/2014 was issued in January 2014, replacing the previous Law No. 32 of 2004 on Regional Autonomy. The Village Law incorporates a number of key Community Driven Development (CDD) principles and institutions, including participatory village planning, implementation of village-level projects, inter-village collaboration, community facilitation and community oversight. Under the Village Law, village governments are responsible for administering village funds (Dana Desa and Alokasi Dana Desa) and accommodating community needs through democratic processes (hamlet and village deliberations). The Village Law introduces an additional function of Village Councils (BPD, Badan Permusyawaratan Desa) to supervise the performance of Village Heads (Article 55).

4.2 Institutional Responsibilities

57. The key institutions involved in the delivery of the INEY Phase 2 PforR are presented in the table below.

Table 4-2 Key Institutional Stakeholders for the Program

Results Area	Responsible Agencies
1 – Strengthening leadership, commitment and accountability for stunting reduction	DLI1: SoVP, Bappenas, BKKBN & MoHA DLI2: MoF & Bappenas DLI3: Bappenas & MoH
2 – Delivery and quality of specific and sensitive interventions	DLI4: MoEC & MoV DLI5: MOH, Bappenas
3 – Service delivery and convergence at district/city level for stunting reduction	DLI6: MOH & MOHA DLI7: Bappenas, MoF, MOHA & MOH DLI8: MoHA, MOF, Bappenas
4 – Service delivery and convergence at village & household level for stunting reduction	DLI9: BKKBN, MoV, MOH & MoF DLI10: BKKBN, MoV, MOH DLI11: MOH, MOHA, MOV

58. For the Village-level delivery of the program, the following institutional arrangement applied:

- Village Government is the key stakeholders for addressing social performance are the village government, and the village and household level healthcare and early years education providers. Village governments play a critical role to ensure availability of nutrition-specific and sensitive interventions at Posyandu and PAUD. Under the Village

Law, village governments are responsible to administer village funds (Dana Desa and Alokasi Dana Desa) and accommodate community needs through democratic processes (hamlet and village deliberations). The role of village governments in mainstreaming health and education into village development plans (RKPDes) and village development budget plans (APBDes), including in determining budget allocation and/or directing how allocated budget is spent, is critical and may continue to become stronger in the coming years.

- Frontline health services are essential for nutrition-specific interventions (supported by the Program) are administered by Puskesmas (public PHCs) and their auxiliary and outreach services, including midwives and nurses. The public primary care system also includes auxiliary Puskesmas (Pustu) for outreach activities in remote regions, village-level delivery posts (Polindes, often the home of the village midwife) and village health posts (Poskesdes). Frontline service delivery at village-level across Indonesia is also undertaken through Posyandu and by village midwives (who are formally part of the health system). Posyandu is a monthly event manned by at least five types of community health workers that cater to the five essential services: registration, weighing and monitoring children's growth, recording of child growth in health cards, counselling and education; immunization and ante and post-natal care as part of outreach services of Puskesmas. Midwives and nurses are important frontline service providers due to their placement and/or operations at the village level and therefore, are more accessible compared to doctors who are mainly based in Puskesmas at the sub-district level. Cadres - who work on a voluntary basis - are not part of the formal health system and do not receive monthly salaries (only minimum transport allowance from village governments).
- PAUD is main stakeholder for the delivery of holistic, integrated early childhood education and development (ECED) are run by PAUD teachers who either serve on a voluntary basis or recruited by the village government, and in some cases paid from parents' contribution/voluntarily fund. PAUD services are demand-driven and there could be a lack of incentives for PAUD teachers to outreach to tend to children from diverse community groups.

4.2.1 Environment

59. Under the INEY PforR, the main institutions which are expected to play a role in environmental management performance include MoH, MOHA and MOEF. The table below describes roles and responsibilities of the institutions in managing the potential environmental risks.

Table 4-3 Institutional Roles and Responsibilities for Environmental Performance

Institutions	Roles and Responsibilities for Environmental Performance
Secretariat of Vice President (SoVP)	SoVP (as PMU) to hire/designate a focal point that able to oversee the overall performance of E&S management of the Program in accordance to regulatory requirements [and the Bank's PforR standards]. The focal point to coordinate with the Bank's E&S Safeguards and other relevant ministries or agencies that has direct control to the implementation of relevant environmental requirements, for example, regarding medical waste handling at PHCs.
Ministry of Health (MoH)	MoH through Directorate General of Public Health (Ditjen Kesmas) and Directorate General of Health Service, in coordination with the MoEF, to coordinate with regional health agencies (Bidang Kesehatan Lingkungan of Dinas Kesehatan) to provide direction and supervision for appropriate medical waste handling at PHCs (e.g., Puskesmas, Posyandu, Poskesdes, etc.). Additionally, to ensure that guidance on strategic, approach, monitoring on any sanitation-related program that is delivered as part of the PHC are received in clear manner by medical staff, voluntary staff or cadres that are involved..

Institutions	Roles and Responsibilities for Environmental Performance
Ministry of Home Affairs (MoHA)	MOHA provides supports to *Posyandu*. Implementation of *Posyandu* requires inter-sectoral collaboration between MOH and MOHA.
Ministry of Environment and Forestry (MoEF)	MoEF has established a Directorate General of Domestic Waste, Waste and Hazardous Waste ('Ditjen PSLB3) that overseen implementation of regulatory requirements particularly on hazardous waste management. MoEF in coordination with MoH, to monitor the implementation of regulation related to medical/pharmaceutical waste management; to issue the permit for medical waste handling companies and storage facilities located in the PHCs; to provide guidance and advise on medical waste management particularly for less developed area where access to the medical waste treatment facilities are very limited.

4.2.2 Social

60. The table below describes roles and responsibilities of the institutions in managing the potential social risks.

Table 4-4 Institutional Roles and Responsibilities for Social Performance

Institutions	Roles and Responsibilities for Social Performance
Secretariat of Vice President (SoVP)	SoVP (and TP2S) has key role in making sure appropriate management of social risks, including in monitoring the inclusion of Indigenous community and vulnerable groups in the program, coordinating preparation of an integrated system and socialization of grievance mechanism (including tracking, recording and resolution), and preparation of plan for capacity building of the health and safety of all workers involved in the program, including at village level.
Ministry of National Planning (Bappenas) and Ministry of Home Affairs (MoHA)	Bappenas roles to undertake the role of monitoring and evaluation for the program, and the MoHA as the Deputy Chair for oversight and monitoring of local governments, are essential in oversee the social risk management implementation.
National Population and Family Planning Board (BKKBN), Ministry of Village (MoV), Ministry of Health (MoH)	Coordination between relevant institutions/agencies (such as BKKBN with its local team, MoV facilitators, MoH through its local health staffs at Puskesmas/Posyandu, and Ministry of Administrative and Bureaucratic Reform (MenPAN-RB) with its Lapor! System) is required, to optimize existing media/channel for receiving and handling concerns, issues, challenges, inputs, and lessons learned, also ensuring accessible grievance mechanism for all stakeholders and diverse community groups/program beneficiaries.
Local government, agencies, and community figures/leaders (including Village/Kelurahan Government, Religious leaders, PAUD, Puskesmas, Posyandu, local cadres and volunteered staffs)	• Local government/agencies (particularly frontline healthcare services) are key stakeholders for addressing social performance particularly in ensuring program inclusion at local (village) and household level. Village government and village level organisations (including community figures and religious leaders) represent communities and advocate their aspirations, including if any concerns/issues related to the program inclusion (under the responsibility of MoV and in coordination with MoSA and/or BKKBN). • Frontline health service providers and early years education providers (such as midwives, nurses and cadres at Posyandu, also PAUD coordinators and teachers) are essential in social risk management to ensure program inclusion and outreach to all community groups (including Indigenous People and vulnerable groups) as well to ensure the health and safety of community members/staffs involved in the program implementation (in provisions of nutrition-specific and sensitive interventions), under coordination of MoH.

4.3 Experience from INEY Phase 1 and Other World Bank Projects

61. With regard to capacity of the project executing agency as well as PIU, the previous assessment from the INEY Phase 1 and during the Phase 2 Concept Stage reported that the IPF component support to SoVP has strengthened national leadership in stunting prevention; SoVP has initiated monitoring and convening of its 2 priority provinces. Remaining gaps and challenges were identified related to the management of ES issues, including in grievance mechanism socialization, monitoring, and reporting. Meanwhile, the allocated grants for MoHA which have been able to finance the existing Technical Assistance Pool to oversight and monitoring of local governments were limited to early stage of program. MoV capacity building also continues with the addition of a data coordinator role at the village level to coordinate with other village actors. In the meantime, BKKBN has moved very quickly to respond to the new regulation mandate as key technical lead of the national stunting prevention program, by collecting field data and carrying out analytics, contributing to updated Convergence Action guidelines in coordination with MoV and MoHA.

62. MOH has prior experience in implementing Bank financed projects. MoH is currently implementing three World Bank-funded projects in the health sector: Indonesia – Supporting Primary Health Care Reform Program (ISPHERE), which have operated for four years and largely focuses strengthening a primary health care accreditation system, Indonesia Emergency Response to COVID19 Program which focus on strengthening key aspects of Indonesia's emergency to the COVID19 outbreak systematically, and Indonesia Strengthening National Tuberculosis Response to improve coverage, quality and efficiency of tuberculosis services in Indonesia.

4.4 Assessment of E&S Capacity and Management System

63. In this section, existing environmental and social system is assessed in light of the Banks' six E&S Core Principles for PforR with the identification of remaining gaps that need to be filled to fully meet the Bank's E&S Core Principles.

Table 4-5 E&S Capacity Assessment and Gap Analysis

64. **Core Principle #1: Program E&S management systems are designed to (a) promote E&S sustainability in the Program design; (b) avoid, minimize, or mitigate adverse impacts; and (c) promote informed decision-making related to a Program's E&S effects.**

No.	Key Attributes related to Core Principles	Provision in the System	Identified Gap	Recommendation of gap-filling measures
1-1	Operate within an adequate legal and regulatory system to guide E&S impact assessments, mitigation, management, and monitoring at the PforR Program level	The overall Program is mandated under the Perpres 72/2021. Additionally, regulatory and legal frameworks related to E&S risks and impacts on the Program are generally available, e.g., regulation on procedures for handling, distributing, and storing supplement, vaccines, vitamins are available; as well as regulation on how to implement immunization activities. Moreover, regulation on PHCs is quite comprehensive including their accreditation system. Also, a clear distinction between national, provincial and district level jurisdiction for permitting system of medical waste management handling at primary care level is available (MoEF Regulation No. 56 of 2015) with regulation on permitting system for wastewater effluent and emission. With regards to social inclusion, including attention to Indigenous People and vulnerable groups, there are a range of provisions in the Indonesia regulations, including the Village Law No.6/2014, PR No. 186/2014, MoSA Regulation No. 12/2015, and MoV Regulation No. 19/2017. The Program is mainly implemented through PHCs and cadres at village level. The existing regulatory instruments (e.g., MoH Reg. 43/19 and MoH Reg. 44/16) define the qualifications of each medical and administrative staffs of the PHCs, which is considered as one of basic safeguard to ensure health, safety, and security of the	• There has not been regulatory or legal basis for Posyandu Prima (still in pilot project). • Medical waste storage in public health facility is not always have their required permit available. • Designated medical waste treatment facility is not always available or accessible in several provinces and in remote areas. • In some regions, some voluntary staff or community workers involved in the program are not always exposed to training events that include safety procedures when doing medical support, using medical equipment. • There is no clear regulatory framework to provide voluntary staff, cadres, or community with trainings to deliver the task securely, for example regarding safety during travelling to remote area or safety requirement for medical handling.	• Ministry of Health to expedite establishment of regulatory or legal basis that defines scope and terms of service, taskforce arrangement, equipment and other supporting instruments for Posyandu Prima. • Local health agency to ensure technical appropriateness of medical waste storage facility in each PHCs in coordination with local environmental agency, and to promote enactment of necessary permitting for the storage facilities once technical requirements are met. Supervision to be reported and discussed with Ministry of Health. • Local health agency to provide guidance for PHCs to ensure an alternative approach to contain/immobilize medical waste as regulated in Appendix VI of MoH Reg. 56/2015 is applied in limitation of access to transport the collected medical waste at designated treatment facility. • Local health agency and PHCs to provide trainings on safety procedures and to use medical or analytical equipment mandated for all staffs including voluntary staff. • Ministries/agencies to develop or include a guideline that focuses on self-safety and security, communication protocol, etc. for voluntary staff, cadres, or community with trainings in delivering the task.

No.	Key Attributes related to Core Principles	Provision in the System	Identified Gap	Recommendation of gap-filling measures
		staffs and patients in providing the medical services.		
1-2	Incorporate recognized elements of good practice in E&S assessment and management, including: (i) Early screening of potential impacts.	Identification of potential E&S risks and impacts and measures to mitigate those topics are embedded in multiple regulatory frameworks specifying procedures to establish, certify, and operate PHCs as the main implementor of the Program as listed below: • MoH's Regulation No. 43 of 2019 regarding Puskesmas; • MoH's Regulation No. 44 of 2016 on Puskesmas Management Guidelines; and • MoH's Regulation No. 34 of 2022 on Accreditation of Puskesmas, Clinic, Laboratory, Blood Transfusion Unit, Private Physician Clinic, and Private Dental Clinic. In addition, separate regulations have been established and implementable as basic framework for identifying as well as mitigating pre-identified risk and impact relevant with the Program. Amongst the regulations are: • MoH's Regulation No. 42 of 2013 regarding 'Immunization' that outlines screening of health risk, prioritization of patient, prevention of contraindication, etc.; • MoH's Regulation No. 51 of 2016 regarding 'Nutritional Supplement Product Standard' that outlines provision requirement, nutritional content, preparation standards, etc.;	Other than what are being mandated in the regulatory requirements, there are no other formal mechanism to conduct self-screening on residual or recently coming up E&S risk and impact; more over to identify and evaluate appropriate mitigation measures that need to be taken. Under the MoEF Regulation No. 4 of 2021 on 'Activity/Business that require Environmental Impact Assessment: AMDAL[10]/UKL-UPL[11]/SPPL[12]' ('MoEF's Reg. 4/2021'), any activities/services conducted by PHCs only required to have an SPPL, which is basically a letter of commitment to manage environmental risk and impact as per regulatory requirement. No formal risk and impact screening, monitoring, and reporting are needed mandated from the SPPL. Additionally, there is no other mechanism to assess certain E&S risk and impact specified in Bank's acceptable standards that has not been covered in the regulatory requirements, for instance, regarding cultural appropriateness and equality of service for Indigenous People and vulnerable groups, risk of gender-based violation, etc.	Secretariate of Vice President (SoVP), as the Project Management Unit (PMU), should assign a dedicated taskforce to conduct supervision on the overall E&S aspect relevant with the implementation of the Program. Despite the absence of formal regulated environmental risk and impact assessment process, the taskforce should cover identification of applicable E&S risk and impact according to Bank's standards, developing mitigation plan and action, and monitor the remained risks and evaluate further action to be taken. The taskforce should be in close coordination with relevant ministries or agencies at national level that will furtherly circulate direction on E&S requirement to be fulfilled to environmental agency and PHCs at district level. It should be noted that the local health agency and PHCs at district level are the entities deal directly with the actual E&S risk and impacts and thus has capacity to provide input on site or cultural-specific mitigation plan and action in a case-by-case basis.

[10] AMDAL: *Analisis Mengenai Dampak Lingkungan Hidup* (Environmental Impact Assessment Document)

[11] UKL-UPL: *Upaya Pengelolaan Lingkungan Hidup – Upaya Pemantauan Lingkungan Hidup* (Environmental Management and Monitoring Effort Document)

[12] SPPL: *Surat Pernyataaan Pengelolaan Lingkungan Hidup* (Environmental Management Statement Letter)

No.	Key Attributes related to Core Principles	Provision in the System	Identified Gap	Recommendation of gap-filling measures
		• MoH's Regulation No. 18 of 2020 on 'Medical Waste Management' and MoEF's Regulation No. 56 of 2015 regarding 'Procedures and Technical Requirements of Hazardous Waste Management of Medical Facilities' that outlines detailed mechanism to manage medical waste; • MoH's Regulation No. 3 of 2014 regarding 'Community-based Total Sanitation' that includes technical specifications for conducting community-based sanitation program; • Some national standards (*Standar Nasional Indonesia,* or 'SNI') for sanitation facility establishment, e.g., SNI 2398:2017 on procedure for septic tank planning, SNI 6774:2008 on procurement of clean water, etc. With regards to social issues: • Risk of inequality in program delivery is expected to be addressed in the selection and proposal of focus villages and/or priority provinces, which is understood will be based on the stunting prevalence data. • Screening of the potential health and safety risk of the involved community (particularly local workers involved in the program delivery at village level) will be conducted against national standards for OHS and Community Health and Safety.		
1-3	(ii) Consideration of strategic, technical, and site alternatives (including the "no action" alternative)	This Program will be implemented as a response of the urgent stunting condition in Indonesia which is at 21.6% by 2022. Strategic and technical approaches have been pre-determined based on multi-sectoral	There is no considerable gap on E&S risks relative to the overall strategy, technical approach, and sites selection that demand alternative to these aspects to be materialized.	No gap-filling measure recommendation applicable for this aspect.

No.	Key Attributes related to Core Principles	Provision in the System	Identified Gap	Recommendation of gap-filling measures
		ministries and agencies agreement by incorporating some lesson learned from INEY-1 program. The Program will need to be implemented for the entire regions of Indonesia, though it will be initiated for 12 priority areas with highest prevalence rate. As such, there is no E&S risks that currently considered material to trigger alternative to the strategy, technical approach, and site.		
1-4	(iii) Explicit assessment of potential induced, cumulative, and transboundary impacts.	The Program is not expected to have cumulative or transboundary adverse environmental and social impacts. Though the Program is to be implemented nationwide, the environmental issues are confined individually in each PHCs that separated one another; while the risk of social inequality and health and safety of community workers would be limited to individual village.	There is no considerable gap on E&S risks relative to the potential induced, cumulative, and transboundary impacts	No gap-filling measure recommendation applicable for this aspect.
1-5	(iv) Identification of measures to mitigate adverse E&S risks and impacts that cannot be otherwise avoided or minimized.	Refer to row 1-2	Refer to row 1-2	Refer to row 1-2
1-6	(v) Clear articulation of institutional responsibilities and resources to support implementation of plans.	The institutional arrangement of the Program appointed SoVP as the PMU of the Program in collaboration with other ministries and regional (provincial and district-level) government, subject to their relevant DLIs. Based on communications with various stakeholders during assessment mission, it is understood that implementation relevant E&S aspects of this Program would fall under responsibilities of regional and local (village) government agencies.	At this moment, there is no formal focal point from the government end that has been appointed to be the Bank's counterpart to ensure appropriate management of identified E&S risk and impact. From assessment mission, it was noted that some misalignments in practical level is possible if there is lack of coordination between institutions. For example, PHCs (with programs derived from Health Ministry and regional government) may not	■ SoVP to appoint a taskforce on E&S aspect as mentioned in row 1-2 and 1-4. ■ SoVP directly or through other ministries or agencies should emphasized the roles and responsibilities of local agencies at district level in the overall E&S aspect management, for example, Health Agency and Environmental Agency for medical waste management, and Civil

No.	Key Attributes related to Core Principles	Provision in the System	Identified Gap	Recommendation of gap-filling measures
			aware that a Family Counseling Team (*Tim Pendamping Keluarga*, or 'TPK', with programs derived from BKKBN) is present thus may not able to work on the Program in synergy. It is also noted that in some regions, PHCs, volunteers, and cadres were expected to take higher responsibilities that supposed to be owned by the regional agencies, e.g., identifying strategy, monitoring, and evaluating for sanitation programs.	Work and Public Housing Agency for provision of sanitary facilities.
1-7	(vi) Responsiveness and accountability through stakeholder consultation, timely dissemination of relevant information, and responsive Grievance Redressal Mechanisms (GRMs)	Perpres 72/2021 encourages all reports in relation to implementation, monitoring and evaluation of the Program to be channeled for communication between government institutions through the integrated portal of Satu Data Indonesia (https://data.go.id/home). Satu Data Indonesia was understood able to archive recapitulation of public grievances collected through online channels, such as Lapor! (which is the existing national complaint handling management system for all public services). Online grievance channel is also used in the more developed provinces/districts such as the Public Online Aspirational and Grievance Service (*Layanan Aspirasi dan Pengaduan Online Rakyat*). On the other hand, in less developed area, dissemination of information and media for covenying concerns and issues such as from PHCs staffs vice versa, is being conducted through a more conventional channel such as through the quarterly multi-sectoral health workshop meeting at district level	There has not been a single nation-wide mechanism that proven to be equally accessible throughout all regions in Indonesia and reliable in terms of demonstrating responsiveness and accountability in addressing grievances. Existing GRM channel ('Lapor!') effectiveness reported to be varied between regions, relative to their internet network coverage and communication device availability. It was noted that the Minilok may not reached all of relevant stakeholders, for example cadres whom recruited under BKKBN's program. There has not been an actual ultimate ministry/agency to own the accountability to oversee adequacy of responses over the grievance. Since currently grievances are reported through several non-integrated reporting mechanisms (through local government online platform, social media, messaging apps, and face to face meeting/communication), responses and action to address those are conducted by	■ SoVP to outline a comprehensive framework for collecting and responding to grievance, which include non-electronic/internet communication as most suitable way for people located in remote area. It should be able to monitor the incoming grievance redirected to Satu Data Indonesia and to evaluate input related to the Program (for example, with keyword of "stunting", "immunization". "supplement nutrition", etc.) if appropriate response have been provided by the recipient agencies and if the grievance addressing process is on track. ■ SoVP to invite and mandate participation of all relevant parties to the Program at district level in Minilok event. In addition to that, to direct local agencies to document any agreed/directed results for further distribution to non-participating organization or person, if any.

No.	Key Attributes related to Core Principles	Provision in the System	Identified Gap	Recommendation of gap-filling measures
		(*Lokakarya Mini Lintas Sektor Kesehatan*, or Minilok). Alternative mechanisms, such as the use of social media (with the identified presence of TP2S in social media), issues and inputs/suggestions might be raised from public via Instagram, Facebook, LinkedIn, etc.; are also available.	respective ministry and agency whom the grievance is addressed.	

65. **Core Principle #2: Program E&S management systems are designed to avoid, minimize, or mitigate adverse impacts on natural habitats and physical cultural resources resulting from the Program. Program activities that involve the significant conversion or degradation of critical natural habitats or critical physical cultural heritage are not eligible for PforR financing.**

No.	Key Attributes related to Core Principles	Provision in the System	Identified Gaps	Recommendation of gap-filling measures
2-1	Identify, and screen for adverse effects on potentially important biodiversity and cultural resource areas and provide adequate measures to avoid, minimize, or mitigate adverse effects.	This Program, by nature, will not introduce major landscape change since it will not cover establishment of associated facilities and infrastructure. Establishment of any facilities and infrastructure that contemporaneously executed along this Progam will be funded by source beyond the PforR scheme. The Program in a way also promotes preservation of natural habitat and physical cultural resources from certain adverse impacts potentially occurring from residential activities, through reduction of the risk of fecal contamination or water-purification chemical contamination on natural water body and soil (Refer to Section 2.3.2).	There is no considerable gap on E&S risks relative to the overall strategy, technical approach, and sites selection that demand alternative to these aspects to be materialized.	No gap-filling measure recommendation applicable for this aspect.
2-2	Support and promote the protection, conservation, maintenance, and rehabilitation of natural habitats.			Not applicable, refer to 2-1
2-3	Avoid significant conversion or degradation of critical natural habitats			Not applicable, refer to 2-1
2-4	If avoiding the significant conversion of natural habitats is not technically feasible, employ measures to mitigate or offset the adverse impacts.			Not applicable, refer to 2-1.

No.	Key Attributes related to Core Principles	Provision in the System	Identified Gaps	Recommendation of gap-filling measures
2-5	Consider potential adverse effects on physical cultural property and provide adequate measures to avoid, minimize, or mitigate such effects.			Not applicable, refer to 2-1

66. Core Principle #3: Program E&S management systems are designed to protect public and worker safety against the potential risks associated with (a) the construction and/or operation of facilities or other operational practices under the Program; (b) exposure to toxic chemicals, hazardous wastes, and otherwise dangerous materials under the Program; and (c) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.

No.	Key Attributes related to Core Principles	Provision in the System	Identified Gaps	Recommendation of gap-filling measures
3-1	Promote adequate community, individual, and worker health, safety, and security through the safe design, construction, operation, and maintenance of Program activities; or, in carrying out activities that may be dependent on existing infrastructure, incorporate safety measures, inspections, or remedial works as appropriate.	This Program is mainly implemented through PHCs and cadres at village level. The existing regulatory instruments (e.g., MoH Reg. 43/19 and MoH Reg. 44/16) define the qualifications of each medical and administrative staffs of the PHCs, which is considered as one of basic safeguard to ensure health, safety, and security of the staffs and patients in providing the medical services. The Perpres 72/2021 has not clearly detailed type of training that the personel on field must have should they are assigned to deliver information and stimulation in the context of stunting reduction. Training on such activities is only mentioned to be designated for early-learning school (*Pendidikan Anak Usia Dini*, or PAUD) teachers. The regulation does not specify if the training will include how to deliver the materials in a way that it is culturally- safe/acceptable, how and to whom they should communicate with, how to go and return from target location, etc.; which is essential to assess ones health, safety, and security aspects in doing their tasks.	It was understood that for some regions, some voluntary staff in PHCs are not always exposed to training events that include safety procedure when doing medical support, or using medical equipment. This type of worker was also reported not always have adequate access to get and use personal protective equipment while doing their service, imposing risk on the personnel health and safety. The current regulatory framework has not specified which parties aside of the PAUD teachers that have to receive particular trainings prior being deployed as a part of the taskforce. The regulatory framework has not specified methodology to deliver the task securely, for example through culturally-acceptable way of communication with the targeted community.	■ SoVP's E&S taskforce through MoH and local health agency to identify required trainings that must be received for any person working in PHCs including the voluntary staffs. The MoH and local health agency to verify that voluntary staffs have equal opportunity to get the training. ■ SoVP's E&S taskforce to insert the element of cultural appropriateness in any preparatory trainings given to medical staffs, voluntary staffs, and cadres assigned to any Program's activities involving engagement with the community.
3-2	Promote measures to address child and forced labor.	The existing regulatory instruments (e.g., MoH Reg. 43/19 and MoH Reg. 44/16) rule out the responsibilities and qualifications of medical and administrative staffs in PHCs. It has not regulated rights and responsibilities of voluntary staffs as worker at the same facilities with the medical staffs. On child labor, some regulatory instruments should apply to the Program, i.e., Act No. 19 of 1999 where it ratified Convention concerning the Abolition of Forced Labor, 1957 (No. 105); and Act No. 13 of 2003 that	It was understood from interviews with voluntary staffs of the PHCs during the assessment mission, that in some regions, a PHC is usually supported by many voluntary staffs. These voluntary staffs are generally working without formal agreement. The voluntary staffs submitted a self-made statement letter to the local health agency that state that they are willing to work without expecting regular compensation and benefit.	MoH and local government agency to define clear roles, responsibilities, and rights of voluntary staffs in doing their task in PHCs. The roles, responsibilities, and rights should be formalized in an agreement that acknowledged by the voluntary staffs and local health agency. None of the agreement may allow violation or deviation

No.	Key Attributes related to Core Principles	Provision in the System	Identified Gaps	Recommendation of gap-filling measures
		mention in Article (69) that child worker (13-15 years old) hiring only under the following terms: ■ written permission from parents or guardians; ■ work agreement between entrepreneur and parent or guardian; ■ maximum working time of 3 (three) hours; ■ carried out during the day and does not interfere with school time; ■ Occupational Health and Safety; ■ there is a clear working relationship; and ■ receive wages in accordance with applicable regulations.	Occasionally, payment is received only when it is budgeted. Some of the voluntary staffs have medical educational background and motivated to work at the PHCs only to obtain an acknowledgement letter from the health agency after finishing their services. Note that there are generally no obligation or binding commitment for the health agency to issue such acknowledgement letters. In absence of the formal work agreements, these voluntary staff could not be identified as workers yet exposed to labor risk including health and safety risk. They are not subject to receive labor-related benefits, such as access to adequate equipment, equality to receive appropriate trainings, admission to health and labor insurances, etc. On the other hand, the voluntary staffs are not bound by any formal responsibilities that allow them to work and treat the patient/community in full compliance with professional standards, SOP, and professional ethics.	from regulatory requirements, including rights to obtain compensation or benefits (including health and labor insurances) when regulated, and obligation to follow medical professional procedures and ethics.
3-3	Promote the use of recognized good practice in the production, management, storage, transport, and disposal of hazardous materials generated under the PforR.	Hazardous waste that is considered relevant and considerable in this Program is limited to medical waste that potentially have their quantities increased due to improvement of medical service delivery (including immunization) brought by the Program throughout the country. Management of medical waste is regulated under provision in the MoEF Reg. 56/15 and MoH Reg. 18/20 (Refer to ***Section 3.1***).	In remote regions or area with limited access to medical waste treatment facilities, medical waste is known to be stored in any available and vacant space (wardrobe, crate, etc.) within the PHCs even though they are not meeting technical requirements as medical waste temporary storage facility. The condition also triggers extensive storing, that could reach up into a year or more, depend to availability of the nearest medical waste destruction or treatment area.	SoVP's E&S taskforce through MoH and local health agency to promote implementation provision of Appendix VI of MoEF Reg. 56/15 for remote areas or areas with limited access to waste treatment facility. Refer to row 1-1.

No.	Key Attributes related to Core Principles	Provision in the System	Identified Gaps	Recommendation of gap-filling measures
3-4	Provide training for workers involved in the production, procurement, storage, transport, use, and disposal of hazardous chemicals in accordance with the relevant international guidelines and conventions.	Any PHCs, from level of sub-district area, i.e., Puskesmas, should have a Sanitarian staff work at the facility. Sanitarian took responsibilities to day-to-day management of medical waste, domestic waste, chemical, pest control, etc. in the facility boundary. A sanitarian must be a person whom graduated from environmental health course in education and other trainings to get sanitarian certifications, i.e. Sanitarian Personnel Registration Certificate (*Surat Tanda Registrasi Tenaga Sanitarian*, or 'STRTS') and Sanitarian Personnel Work Permit (*Surat Izin Kerja Tenaga Sanitarian*, or 'SIKTS'). Complete regulatory framework to ensure competency of a sanitarian is available in the Minister of Health's Regulation No. 32 of 2013 on 'Provision of Sanitarian Personnel' ('MoH Reg. 32/13').	Sanitarian assigned in PHCs of remote area or area with limited access to medical waste treatment facility, may not be familiar with (or have not always receiving direction from governing agency) to implement an alternative approach to contain/immobilize the medical waste as per the Appendix VI of MoEF's Reg. 56/15 (Refer to Row 3-3).	SoVP's E&S taskforce through MoH and local health agency to guide sanitarian in PHCs to implement provision of Appendix VI of MoEF Reg. 56/15 for remote areas or areas with limited access to waste treatment facility. Refer to row 1-1 and 3-3.
3-5	Apply adequate measures to avoid, minimize, or mitigate risks for the community, individual, and worker exposure to natural hazards such as floods, hurricanes, earthquakes, or other severe weather or affected by climate events.	The Program will not include significant structural development that potentially increase risk of exposure of community or worker involved to naturally-occurring hazard or the ones triggered by climate events.	The aspect is considered not applicable with the Program scope.	No recommendation is proposed.

67. **Core Principle #4: Program E&S systems manage land acquisition and loss of access to natural resources in a way that avoids or minimizes displacement and assists affected people in improving, or at the minimum restoring, their livelihoods and living standards.**

No.	Key Attributes related to Core Principles	Provision in the System	Identified Gaps	Recommendation of gap-filling measures
4-1	Avoid or minimize land acquisition and related adverse impacts.	By nature, this Program will not include any landscape change that requires land acquisition.	The aspect is considered not applicable with the Program scope.	No recommendation is proposed.
4-2	Identify and address economic or social impacts caused by land acquisition or loss of access to natural resources, including those affecting people who may lack full legal rights to resources they use or occupy.			Not applicable, refer to Row 4-1
4-3	Provide compensation sufficient to purchase replacement assets of equivalent value and to meet any necessary transitional expenses, paid before taking land or restricting access.			Not applicable, refer to Row 4-1
4-4	Provide supplemental livelihood improvement or restoration measures if taking of land causes loss of income-generating opportunity (e.g., loss of crop production or employment).			Not applicable, refer to Row 4-1
4-5	Restore or replace public infrastructure and community services that may be adversely affected by the Program.			Not applicable, refer to Row 4-1
4-6	Include measures for land acquisition and related activities to be planned and implemented with appropriate disclosure of information, consultation, and informed participation of those affected.			Not applicable, refer to Row 4-1

68. Core Principle #5: Program E&S systems give due consideration to the cultural appropriateness of, and equitable access to, Program benefits, giving special attention to the rights and interests of Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities, and to the needs or concerns of vulnerable groups.

No.	Key Attributes related to Core Principles	Provision in the System	Identified Gaps	Recommendation of gap-filling measures
5-1	Undertake meaningful consultations if the Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities or ethnic or racial groups are potentially affected (positively or negatively),	The program intended for the interventions to be undertaken in priority area with high stunting prevalence that will potentially benefit Indigenous Peoples, including remoted indigenous communities. This is aligned with the existing Indonesia regulation which has recognized and respect for communities living by the customary law (Adat) and traditional value systems.	Program implementation at local (district and village) level very much depend on the local government capacity, while the practice for engagement with Indigenous community for stunting reduction is varied.	Community level systems exist to enable participation, such as through BKKBN's Family Facilitators and Cadres, in coordination with the local Puskesmas/Posyandu and the MoV HDW/Village Facilitators

No.	Key Attributes related to Core Principles	Provision in the System	Identified Gaps	Recommendation of gap-filling measures
	to determine whether there is broad community support for the PforR Program activities.	In more recent practice, BKKBN has initiated the engagement and involvement of indigenous community in leading the stunting reduction program implementation at local level (as reported in https://www.bkkbn.go.id/). Although cultural barrier was often identified as one of the key challenges of INEY 1 in achieving the stunting reduction target, and data shown that stunting prevalence is noticeably high among indigenous people and in rural communities reportedly in some regions, there are areas across Indonesia with useful Indigenous knowledge to support the stunting reduction, including in South Sulawesi (as reported in https://www.ekuatorial.com/).		
5-2	Ensure that Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities can participate in devising opportunities to benefit from exploitation of customary resources and indigenous knowledge, the latter (indigenous knowledge) to include the consent of Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities.			Not relevant
5-3	Give attention to groups vulnerable to hardship or discrimination, including, as relevant, the poor, the disabled, women and children, the elderly, ethnic minorities, racial groups, or other marginalized groups; and if necessary, take special measures to promote equitable access to project benefits.	The program intended for the interventions to be undertaken in priority area with high stunting prevalence that will potentially benefit vulnerable people, including lagging community and poor households, and other vulnerable groups. This is aligned with the existing Indonesia regulation such as through the MoSA Regulation No. 12/2015 and MoV Regulation No. 19/207 which include provisions to improve the welfare of vulnerable groups.	Vulnerable groups identified based on literature review and fieldwork. Practice on inclusive approaches still under assessment.	Community level systems exist to enable participation, such as through BKKBN's Family Facilitators and Cadres, in coordination with the local Puskesmas/Posyandu and the MoV HDW/Village Facilitators

69. Core Principle #6: Program E&S systems avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.

No.	Key Attributes related to Core Principles	Provision in the System	Identified Gaps	Recommendation of gap-filling measures
6-1	Consider conflict risks, including distributional equity and cultural sensitivities.	By nature, priority area of the Program implementation will be influenced by the stunting prevalence, thus might be implemented in area with social conflict of post-conflict areas. However, the scope of program implementation is not expected to create significant social issues/risks which may trigger or exacerbate conflict, thus this principle is considered not applicable for the Program.	The aspect is considered not applicable with the Program scope.	No recommendation is proposed.

5. RECOMMENDATIONS OF PROJECT ACTION PLAN

5.1 Conclusions

70. The PforR aims to enhance the delivery and convergence of services to accelerate the reduction of stunting in Indonesia. The ESSA noted that regulatory requirements pertaining procedures and requirements to manage identified E&S concern that is relevant to implement the Program have been established in Indonesia. It is noted however that such procedures and requirements have not been able to be implemented equally all across Indonesia, due to various baseline conditions, such as access to medical waste treatment facilities, access to clean water, access to sanitation facility, cultural background, etc.

71. Through E&S screening, the PforR's overall E&S risk rating is Moderate, with environmental risk rated Moderate and social risk rated Moderate.

72. Following areas have been identified to be improved:

a. Person or taskforce dedicated to conduct supervision of overall E&S performance against GOI regulation and Bank Standards and to conduct coordination within and between appointed ministries/agencies have not been appointed or procured.

b. Best management practice based on regulatory requirements regarding medical waste management has not been implemented consistently throughout Indonesia due to limited access to treatment facility, while medical or sanitarian units in less developed area have not fully aware of presence of alternative direction to manage medical waste in such condition.

c. Coordination between local health agency and PHCs have yet reached a point where the PHCs staffs are able to fully understand the goals and strategy of sanitation improvement program hence they could deliver the program in the most acceptable approach and to monitor the changes appropriately for further evaluation.

d. Assessment undertaken during project preparation informed that communities in remote areas and vulnerable groups experience (and more prone to) challenges to access the educational program, as well as in receiving nutrition specific interventions, particularly health services. It was observed that in the remote or traditional community, cultural barrier in receiving nutrition specific were still presence, while poor families with lesser education and limited access to advance health knowledge were still having low awareness on the urgency of pregnant mother and child nutrition in affecting stunting.

e. Attention to be provided to voluntary staffs in PHC, and community workers and cadres to receive adequate trainings covering health, safety, and security aspects while conducting their assignments.

f. Potential for inequality might create risk of conflict which stems from real or perceived differences in how the benefits of the program are distributed which makes the need for an effective grievance system important. It is understood that multiple channels are used in practice, thus an integrated mechanism/system to manage concerns/issues, challenges and inputs from the affected people/beneficiaries and stakeholders are required.

5.2 Recommendation

73. To provide guarantee that the Program will consider and implement best practice approach on environmental aspects per regulatory instruments, the following items are recommended: (1) It is recommended that the ESSA's action plans associated to medical waste management are included in the verification protocol for Disbursement-linked Indicators (DLI) 6 regarding provision of high quality essential health and nutrition services in Puskesmas; and (2)

Improvement of water and sanitation services to be included as one of parameters in the convergence effort, and to be verified as one of key indicator during budget preparation at district/city level prior to disbursement of DLI 8 (Districts achieve good performance in converging the acceleration of stunting reduction).

74. The ESSA also identified additional recommendations on social gaps filling measures, including: (1) further improvement on coordination among the relevant ministries is still required to ensure that all grievances are documented, reported, followed up, and appropriately resolved; this action is recommended to be embedded in the DLI 3 on Comprehensive Monitoring and evaluation system to enhance the stunting reduction program where the feedback/ concerns from the citizen related to the program and how these are being resolved to be part of the verification protocol, in which relevant information to be consolidated and submitted bi-annually by the Bappenas; and (2) to address the risk related to occupational health and safety (OHS) of workers involved in the operationalization of the program, particularly the community workers in Pustu/Posyandu, the proposed action plans to be incorporated in the verification protocol of the DLI 9 to ensure Village kaders have skills and support to deliver quality essential health and nutrition services and coordinate service convergence, including capacity related to OHS.

5.3 Project Implementation Support and Recommended PAP

75. Following actions are included in the Program Action Plan (PAP) to be undertaken during the PforR implementation:

Table 5-1 Environmental and Social Measures for the Program Action Plan

Action Description	Responsibility	Timing	Completion Measurement
POM preparation/updates, to include: (a) mechanism of regular coordination between agencies (e.g., with MoH, MoEF, MOHA, BKKBN, Bappenas, etc.), (b) coordination with other projects (as relevant, e.g., ISphere PforR, COVID PforR, other health projects in the future, village government capacity building program, etc.), and (c) E&S risks management monitoring and reporting. Regular project reporting to the Bank to include updates on the E&S mitigation implementation.	SoVP	Prior to project effectiveness date	POM completion has included (a) procedure of coordination between agencies, (b) coordination with other relevant projects, and (c) E&S risks management monitoring and reporting.
Environmental Specialist and Social Specialist or Focal Points to be recruited/appointed/assigned to oversee implementation, monitoring, reporting and mainstreaming of E&S management.	SoVP	Whole implementation stage	Provision of contact person or team of the E&S focal points to the Bank's E&S Safeguards, followed with continuous coordination along the whole program implementation stage.
Awareness raising, refresher training, mainstreaming of E&S management, and access to information to medical waste facilities at provincial level and PermenLH 56/2015 are included in the eHDW (electronic Human Development Workers) application for 74,000 villages in Indonesia through KPM (Kader	MoV, MoHA, BKKBN	Whole implementation stage	eHDW and AKSI BANGDA applications are equipped with information related to the procedures on medical waste handling, awareness raising and training materials, guidelines and

Pembangunan Manusia) from Ministry of Village and also AKSI BANGDA application from Ministry of Home Affairs.			information of the closest medical waste facilities. This is proposed to be included as a requirement in the verification protocol for DLI 6 on this aspect.
Regular training and supervision of PHC's staff and sanitarian by local health agencies on implementation of MoH's Regulation No. 18 of 2020 (Permenkes 18/2020) on **medical waste handling** or for remote area, implementation of Appendix VI of the MoEF's Regulation No. 56 of 2015 (Permen LH 56/2015). One national level workshop on the subject and a local health agencies' report on actual implementation of the provisions on medical waste management in all PHCs, subject to their respective access to the existing waste treatment facilities is proposed to be conducted/provided as a requirement in the verification protocol for DLI 6 on this aspect.	MoH and local health agency for Puskesmas, Posyandu Kader	Whole implementation stage	One national level workshop on the subject and a local health agency's report on actual implementation of the provisions on medical waste management in all PHCs, subject to their respective access to the existing waste treatment facilities. These activity/item is proposed to be included as a requirement in the verification protocol for DLI 6 on this aspect.
Close coordination between Bappeda, MoH, local health agencies, local public work agencies and MOHA on the goals and strategy of sanitation improvement program, as well as evaluation on approach of delivery, monitoring, and evaluation. Evidences that can demonstrate coordination for the goal, strategy, monitoring and evaluation of the sanitation program is proposed to be provided as a requirement in the verification protocol of DLI 8 on this aspect.	SoVP, Bappeda, MoH, local health agency	Whole implementation stage	Evidences that demonstrate coordination for the goal, strategy, monitoring and evaluation of the sanitation program. This item is proposed to be included as a requirement in the verification protocol of DLI 8 on this aspect.
On social inclusion (including IP, remote area community/village, and other vulnerable groups), a technical guideline to be prepared in guiding the Program implementer, particularly at local (District and Village) level to ensure consideration of cultural appropriateness of activities, equitable access to program benefits, and strategy/special attention are provided (e.g., for data collection and specific approach to response when stunting is identified). Training and socialization of the technical guideline to be conducted aligned with the existing capacity building program for the national stunting program implementer at local level.	BKKBN, MoV, and Village Government	In stages, throughout program implementation	Technical guideline has been prepared, socialized and embedded in the existing government training program.
With regards to **community (workers) occupational health and safety (OHS)**, to prepare OHS training module and capacity building plan (including for PusTu/Posyandu staffs and cadres). This is proposed to be incorporated in the verification protocol of the DLI 9 to ensure Village	MoH and local health agency	In stages, throughout program implementation	OHS training module for community workers has been prepared, socialized and embedded in the existing training program.

kaders have skills and support to deliver quality essential health and nutrition services and coordinate service convergence, including capacity related to OHS.			
For **mechanism to manage concerns/issues, challenges and inputs from the affected people/beneficiaries and stakeholders**, a technical guideline to be prepared to cover management of multiple existing grievance channels and media (at national and local level) to be optimized, while ensuring the E&S Focal Point has a system in place to coordinate with relevant ministry and agency, socialization of such channel and system, monitor and report regularly on the resolution of concerns/issues and challenges. Evidence on improvement on coordination between ministries and agencies to address such concerns where the feedback/ concerns from the communities and stakeholders related to the program and how these are being resolved is proposed be included as requirement in verification protocol of DLI 3 on this aspect.	SoVP, MoV and Village Government	In stages, throughout program implementation	Technical guideline has been prepared and socialized, along with regular reporting of grievance status/ updates included in the program regular reporting to the Bank. Evidence on improvement on coordination between ministries and agencies to address such concerns is proposed to be included as requirement in verification protocol of DLI 3 on this aspect.

Annex A Stakeholder Engagement and Site Visit Summary

A.1 INEY 2 Preparation Mission, Jakarta, December, 2022

Date	Stakeholders consulted	Topics discussed
09/12/2023	Secretariat of the Vice President (SoVP), Coordinating Ministry for Human Development and Culture (Kemenko PMK), Ministry of National Development Planning/National Development Planning Agency (Bappenas), Ministry of Finance (MoF), Ministry of Home Affairs (MoHA), Ministry of Health (MoH), Ministry of Village, Disadvantaged Areas and Transmigration (MoV), Ministry of Education, Culture, Research and Technology (MoECRT), Ministry of Social Affairs (MoSA), National Population and Family Planning Agency (BKKBN), National Statistics Agency (BPS)	Kick Off meeting
12/12/2023	MoHA– Director General of Regional Development, Bappenas, MoF –Directorate General of Fiscal Balance	DLI 7 Discussion: Predictability and results orientation of fiscal transfers that support convergence
	MoH –Directorate General of Public Health	Strengthening Primary Healthcare
	SoVP	Discuss DLI 1 and overall management and progress of INEY implementation (IPF, E&S)
13/12/2023	BKKBN, World Bank, SoVP	Preparation of BKKBN to be PIU of INEY
	Bappenas, MoF – Director General of Budgeting	DLI 2 Discussion: Tracking and performance evaluation of national spending on priority nutrition interventions
	MoH –Directorate of Health Promotion, Director General of Public Health, Ministry of Communication and Informatics: Directorate of Informatics and Communications for Human and Cultural Building	DLI 6 Discussion: Priority District implementation of locally-adapted IPC activities
	Bappenas, BKKBN, MoHA – Director General Village Development	Monitoring and Evaluation
14/12/2023	SoVP, Tanoto Foundation, Bill and Melinda Gates Foundation, KFW, Global Financing Facility	IHCA Steering Committee
	MoECRT	DLI 4: Early Childhood Education and Development
	MoSA – Director General of Community Empowerment; Bureau of Planning, Kemenko PMK, TNP2K	DLI 5: Discussion on *Sembako* Program
	MoV Development of Disadvantaged Regions and Transmigration of Republic of Indonesia, MoF – Directorate of Public Budget Transfer, SoVP	DLI 9: Reporting of village convergence; and DLI 10: Convergence in the home
	MoF – Directorate General Of Budget Financing and Risk Management	Discussion with MOF- DJPPR
15/12/2023	SoVP, Kemenko PMK, MoH, MoV, MoHA, BKKBN, Bappenas, Representative of local government and frontliners, Tanoto	Multi-agency workshop to follow up on village-level coordination
16/12/2023	SoVP, Kemenko PMK, Bappenas, MoF, MoHA, MoH, MoV, MoECRT, MoSA, BKKBN, BPS, SoVP	Wrap-up Meeting

A.2 INEY 2 Preparation Mission, Jakarta, Surabaya, Sragen and Manggarai Timur February, 2023

Date	Location	Stakeholders consulted	Topics discussed
07/02/2023	Hotel Aryaduta, Tugu Tani Jakarta Pusat	WB, MoF, SoVP, MoH, Bappenas, MoHA, MoV, BKKBN, KemenkoPMK, MoEC, DJSN, BPJS, KemenPAN-RB, PKK	Mission kick-off meeting; objectives: 1. Introduce team and outline mission objectives 2. Share a preliminary mapping of the roles and responsibilities of key INEY2 stakeholders 3. Technical discussions 4. Agreed on the proposed mission schedule
	Kemenkes Office	WB, MoH (Roren & Imunasi)	Meeting to discuss World Bank's Investing in Nutrition Early Years (Phase 2) Program, proposed to be cofinanced with Gavi
08/02/2023	Ruang Rapat Lt-5 Grand Kebon Sirih	SoVP	**Deep-dive discussions; objectives:** 1. Discuss the technical scope of INEY 2 and potential DLIs and targets 2. Discussion (Feb 8, 2023): 1. Stunting reduction team 2. Puskesmas service strengthening 3. Adolescent 3. DLI 2 discussion including expansion to sub-national tagging and tracking (Feb 9, 2023) 4. Garner feedback on roles, responsibilities and result indicators **5.** Identify technical needs and
	BKKBN Office	BKKBN, SoVP	
09/02/2023	GKS office, level 5	MoH –Gizi, MCH, Promkes-Posyandu	
	Hybrid, place tbd	Kemenko PMK, SoVP	
	Bappenas office	MoF (DTK), Bappenas (KGM), MoHA (Bangda SUPD III), SoVP	
10/02/2023	Hybrid, Bappenas office	MoF (DJA, DJPK), Bappenas (KGM), MoHA (Bangda SUPD III), SoVP	
10/02/2023	Workshop, Hotel Venue	SoVP, MoH, MCoI, BKKBN, Rep of Magelang and Manggarai Timur District, IDCOMM	**Behavioral Change (BCC) Technical Assistance Phase 1** **Findings, Lessons Learned, and Recommendations** **Dissemination Workshop** 1. To share findings, lesson learned, model of TA support, and recommendations from implementation of district BCC TA in Kota Magelang and Manggarai Timur 2. To gather feedback from key line ministries (MoH, MoC&I, and BKKBN) in strengthening the TA for phase two (BCC implementation quality assessment) and potentially using the established BCC TA materials for other districts

Date	Location	Stakeholders consulted	Topics discussed
			3. To discuss how the results from the BCC TA implementation may be used to restructure DLI6 for INEY 2
11/02/2023	Bangda Office	MoHA (Bangda & Adwil), BKKBN, MoV, and MoH	**Deep-dive discussions; objectives:** 1. Discuss the technical scope of INEY 2 and potential DLIs and targets 2. Discussion: village coordination, integration planning process and Kalurahan and Kecamatan role 3. DLI 4 but also discuss parenting education 4. Garner feedback on roles, responsibilities and result indicators 5. Identify technical needs
		SoVP and MOEC	
14/02/2023	SoVP office	MoF, SoVP, MoH, Bappenas, MoHA, MoV, BKKBN	**IPF Component Discussions:** Discuss activities, implementation arrangements, financial management, procurement, environmental and social framework, gender, climate change
	Online	KemePAN-RB, SoVP	Discuss on policy and strategy of digital utilization to accelerate stunting reduction to support Perpres 72/2021
15/02/2023		MOH, MOHA – Bina Pemdes, MOHA – Bina Bangda, MoV, BKKBN	Discussion on integrated village health post services (Posyandu Prima)
	Bappenas office	Bappenas, BKKBN, SoVP	Discussion on MonEv system
16/02/2023	Surabaya Field Visit – Posyandu Prima Jambangan	Mr Regional Secretary Assistant for Governance and People's Welfare Assistant for Economy and Development General Administration Assistant Head of the Regional Development Planning Agency, Research and Development Head of the Health Service Head of Social Service Head of the Office of Women's Empowerment and Child Protection as well as Population Control and Family Planning Head of Communication and Information Service Head of the Education Office Head of the Library and Archives Service Head of Government and People's Welfare Section	1. Surabaya converted a Pustu to a Posyandu Prima as part of the the MoH's Primary Care Integration (ILP) 2. Assess the implementation of the Posyandu Prima in Surabaya

Date	Location	Stakeholders consulted	Topics discussed
		Head of Organizational Section Representative of BKKBN East Java Province District of Jambangan Village Head of Kebonsari Village Chief of Jambangan Village Chief Kara Pagesangan village head Head of TP PKK Jambangan District TP PKK in Jambangan District Jambangan Police Chief Jambangan Military Command KUA Jambangan District Head of LPMK Kec. Vase Posyandu Prima cadres 19 people Great Surabaya Cadres 10 People TPK cadres 24 people (4 sub-districts per sub-district 2 teams/ 6 people) Bangda Team (5 people) Group of Guests/Team (15 people)	
17/02/2023	Surabaya Field Visit – Mayor's Office	Chairman of TP PKK Surabaya City Mr Regional Secretary Assistant for Government and People's Welfare Assistant for Economy and Development Assistant General Administration Head of Regional Development Planning Agency, Research and Development Service for Women's Empowerment and Child Protection as well as Population Control and Family Planning Head of Health Service Head of Social Service Head of Food Security and Agriculture Service Head of Communication and Information Service Heads of Culture, Youth and Sports Services and Tourism Head of Water Resources and Highways Service	Discussion with Head of Kelurahan, Cadres, TPK and Posyand Cadres

Date	Location	Stakeholders consulted	Topics discussed
		Head of Education Office Head of the Department of Transportation Head of Goods/Services Procurement and Development Administration Head of Government and People's Welfare Section Head of the Surabaya City Ministry of Religion Director of PDAM Surya Sembada LGCB ASR Reg 3 Teams	
20/02/2023	Sragen Field Visit – Posyandu	Bapperida, Department of Health P2KBP3A Service, PMD Service	1. Dialogue with the Regent of Sragen 2. Visits and dialogues at posyandu 3. Posyandu name: 4. Mardi Lestari, Dk Karangmalang, RT. 20 Puro Village 5. Visits and dialogues at the Karangmalang Health Center
21/02/2023	Sragen Field Visit – Posyandu & Puskesmas	Bapperida, Department of Health P2KBP3A Service, PMD Service	Discussion/Dialogue with Village Officials
22/02/2023	Sragen Field Visit – Sambiloto Hall Health Office PIC : PMD Service	Head of TPPS Kab. Sragen (Deputy Regent of Sragen) Secretary/Assistant/Head of Service/P2KBP3A PMD Service	Discussions/dialogues with TPPS, sub-district heads, health centers, Community Empowerment TA, Stunting Task Force
23/02/2023	Secretariat's Up Room	Participants from elements: Kades, KPM, TPK, Posyandu Cadres, TP-PKK	1. Monev FGD facilitated by Bappenas 2. Discussion on the implementation of monitoring and evaluation in the field (implementers, tools, systems, data integration between OPDs) 3. Constraints on monev implementation 4. Recommendations for improvement
20/02/2023	Manggarai Timur Field Visit	Vice Bupati Sekda District Secretary TPPS Borong District Head of Dinas Offices (Health, Education, DP2KBP3A, PUPR, Religious Affair , DPMD Head Peot Health Center TPK	Welcoming the mission team and introduction of the team
		Bappelitbangda Department of Health DP2KBP3A DPMD TPK	Discussion /dialogue with Vice Bupati, Sekda, Head of Bapelitbangda, TPPS, head of Dinas offices, Camat, Head Health on Stunting acceleration program in Borong District, Role for each sectoral offices, achievement, challenges

Date	Location	Stakeholders consulted	Topics discussed
		Tenaga Profesional Pendamping Desa and Pendamping Desa DP2KBP3A DPMD	Discussion and dialogue on stunting acceleration program, role and responsibility of different sectors, challenges
21/02/2023	Manggarai Timur Field Visit	Religious leader from Catholoc Church Bappelitbangda Department of Health DP2KBP3A DPMD TPK Village Head of Satar Peot Head Peot Health Center TP. PKK, Satar Peot Village Posyandu cadres Companion Team Family Satar Peot Village KB field Extension Human Development Cadres Satar Peot Village	Dialogue with Romo and visits to Church Visit to Peot Health Center and Posyandu Satar Peot Village and discuss with key multisector actors in the village on stunting prevention program
22/02/2023	Manggarai Timur Field Visit	World Bank Team and Ministries/Agencies Bappelitbangda Department of Health DP2KBP3A DPMD Stunting Companion Team	Coordination /Dialogue with Regent East Manggarai
		World Bank Team and Ministries/Agencies Bappelitbangda Department of Health DP2KBP3A DPMD Stunting Companion Team Head Peot health center and staff	Visit to Peot Health Center
		World Bank Team and Ministries/Agencies Bappelitbangda Department of Health DP2KBP3A DPMD Stunting Companion Team Head of Bangka Kantar Village Head Peot Health Center TP. PKK of Bangka Kantar Village Posyandu cadres TPK Bangka Kantar village, family Planning Field KB Extension	Visit to Posyandu Bangka Kantar Village, observed posyandu activities and dialogue on ongoing stunting prevention program, achievement, challenges, multistakeholders coordinations

Date	Location	Stakeholders consulted	Topics discussed
		Bangka Kantar Village Assistant Bangka Kantar Village Human Development Cadres	
24/02/2023	Online	Bappenas	Rice fortification
	SoVP office	MoF, SoVP, MoH, Bappenas, MoHA, MoV, BKKBN, KemenkoPMK, MoEC, DJSN, BPJS, KemenPAN-RB, PKK	**Mission debrief meeting; objectives:** 1. Review mission findings and DLI proposals, including key agreements and next steps

Annex B ESSA Public Consultation

[To be completed once ESSA draft has been consulted with RSA]

Annex C Summary of INEY 2 DLIs

Summary of INEY 2 DLIs are presented in the following table.

Results Area		Disbursement-linked Indicators (DLI)	Descriptions
1	**Strengthening leadership, commitment, and accountability for stunting reduction**	DLI 1: Commitment, performance and accountability of district & provincial leaders to accelerate stunting prevention	1.1 SoVP, BKKBN, Kemenko PMK, Bappenas, MOHA, MOH and MOV co-organize a national stunting summit each year focused on district and provincial performance
		DLI 2: Results-Based and Climate-Responsive Nutrition Planning and Budgeting Systems	2.1 The GOI, through Bappenas (a) approves a national climate and nutrition action plan and monitoring framework; and (b) reports annually on progress as part as annual Perpres MonEv reports.
			2.2 Bappenas and MOF have updated the budget tagging, tracking, and evaluation procedures to incorporate non-financial performance and location data, as per the verification protocol
			2.3 MOF and Bappenas issue annual and semi-annual performance and expenditure reports and use the budget tagging dashboard to inform the budget of the next FY
		DLI 3: Integrated monitoring and evaluation (M&E) systems for the acceleration of stunting reduction	3.1 MOH has published national and district stunting rates on a government website
			3.2 Bappenas has published its analysis of the new M&E guidelines pilot and updated M&E guidelines for national, provincial, district, and village levels with detailed technical guidance
			3.3 Bappenas and BKKBN have provided semi-annual reports to the Steering Committee including progress and key bottlenecks with recommendations for program improvement
2	**Delivery and quality of specific and sensitive interventions**	DLI 4: Priority districts implement holistic integrated early childhood education (PAUD) centers **OR** Scale up of national nutritional action program (aksi bergizi) to provide support for adolescent nutrition in school	4.1 MOHA, MOECRT and Kemenko PMK roll out up to holistic integrated PAUD centers (scalable)
			4.2 Number of districts implementing the aksi bergizi program to improve adolescent nutrition in schools has increased (scalable)
		DLI 5: Evidence-based nutrition-specific interventions	5.1 Updated guidelines, nutrition status data and new nutrition specific interventions are implemented
			5.2 Nutrition surveillance system is strengthened

			5.3 MOH supports improved quality of nutrition-specific service delivery at subnational level
3	**Service delivery and convergence at district/city level for stunting reduction**	DLI 6: Improving the quality and coverage of essential health and nutrition services at Puskesmas	6.1 More public primary health care facilities meet service-readiness standards for pregnant/maternity, infants and children, and adolescents
			6.2 Number of Puskesmas regularly submitting digital, standardized reports
			6.3 Percentage of adolescent girls receiving Iron Folic Acid Tablets (TTD) in priority provinces (as defined by MOH from time to time) (Number of districts in identified priority provinces with >=3 percentage point increase in coverage for TTD in each year- scalable)
			6.4 Percentage of women receiving the sixth ANC visit according to standards in the verification protocol
			6.5 Percentage of under-five children receiving complete basic immunization in selected, underperforming districts (Number of identified underperforming districts with >=3 percentage point increase in coverage for complete basic immunization in each year- scalable)
			6.6 Percentage of children receiving DTP1 in priority provinces (Number of districts in identified priority provinces with >=3 percentage point increase in coverage for DTP1 in each year- scalable)
		DLI 7: Performance-based fiscal transfers incentivize the district level to converge the acceleration of stunting reduction	7.1 Guideline and verification manual for Performance-Based allocation for BOK Puskesmas include indicators that reward improvement in maternal and child services including immunization
			7.2 Number of districts that have improved performance (as specified in the Verification Protocol) based on the relevant essential health and nutrition service indicators over the baseline year in 2023-24
		DLI 8: Districts achieve good performance in converging the acceleration of stunting reduction	8.1 MOHA updates district convergence action guidelines and performance assessment methodology and, together with MOF, issues the report of district stunting budget tagging and expenditure tracking
			8.2 Number of Priority districts that include stunting reduction as medium-term plan (RPJMD) indicators
			8.3 Number of district/city Regional Governments achieving good performance (as defined in the Verification Protocol) in converging the Acceleration of Stunting Reduction.
4	**Service delivery and convergence at**	DLI 9: Village frontline volunteers (kaders) have skills to deliver quality essential health and	9.1 (a) BKKBN, MOH, MOV and MOHA endorse an integrated training module for implementation of the stunting reduction program at the village level, as per verification

	village & household level for stunting reduction	nutrition services and coordinate service convergence	protocol; (b) MOH finalizes and issues a training on 25 competencies and standard home visits for posyandu kader; (c) MOHA, with support from MOV, issues regulations on the use of subnational budget (APBDes/APBD) to support incentives for village frontline kaders
			9.2 Number of villages with each category of frontline kaders (TPK, KPM, Posyandu) trained in the respective updated module, as per
		DLI 10: Villages achieve good performance in converging the acceleration of stunting reduction	10.1 Guideline issued on: (a) the integration of village and household interventions and convergence for stunting reduction; (b) guidelines on dana desa expenditure for stunting reduction updated according to guidance from line ministries; (c) coordinating the roles and tasks of various program facilitators in the village including the role of Kecamatan; and (d)integration o\f village planning with district planning including the roles of kecamatan.
			10.2 Number of villages achieving good performance in converging the acceleration of stunting reduction as defined in the Verification Protocol
		DLI 11: Posyandu strengthening for provision of quality of essential health and nutrition services	11.1 (a) MOH, MOHA, and MOV issue a joint decree for posyandu, including standardized responsibility and incentive for kaders; (b) Number of Posyandu with at least 2 kaders certified at madya (MCH + school age + adolescent) or higher levels
			11.2 (a) Number of active posyandu (as defined in the verification protocol) across Indonesia; (b) Number of active posyandu regularly reporting patient data and regular monthly reports
			11.3 (a) MOH, MOHA, and MOV issue a joint decree for a comprehensive village health post delivering minimum standard of service; (b) Number of comprehensive village health posts established and functional; (c) Number of comprehensive village health posts regularly reporting patient data and submitting monthly reports

Annex D E&S Risk and Impacts Screening

Result Areas & Activities	Environmental Risks	Social Risks	Proposed PAP	Link to DLIs
Results Area 1. Strengthening leadership, commitment and accountability for stunting reduction	The activities under RA1 are not expected to have significant adverse and long-term direct environmental impacts. Potential environmental benefits: Improved and strengthened governance at district and provincial level could potentially enhance the effectiveness and compliance of environmental protection laws and regulations.	The activities under the RA1 are expected to contribute to addressing equity issues, thus the downstream implications of the key program results to community are expected to be positive, whilst capacity strengthening activities will also benefit national stakeholders (including strengthen multisectoral coordination and through provision of technical support to sector line agencies in data collection, diagnosis, synchronized planning, budgeting, monitoring and evaluation through performance assessments of national spending on nutrition interventions, and acceleration of learning), and therefore the risk has been rated as moderate, given the scale and complexity of the project and nationwide coverage.	• POM preparation/updates, to include: (a) mechanism of regular coordination between agencies (e.g., with MoH, MoEF, MOHA, BKKBN, Bappenas, etc.), (b) coordination with other projects (as relevant, e.g., ISphere PforR, COVID PforR, other health projects in the future, village government capacity building program, etc.), and (c) E&S risks management monitoring and reporting. Regular project reporting to the Bank to include updates on the E&S mitigation implementation. • Environmental Specialist and Social Specialist or Focal Points to be recruited/appointed/assigned to oversee implementation, monitoring, and reporting of E&S management.	-
Results Area 2. Delivery and quality of specific and sensitive interventions	The activities under RA3 are not expected to have significant adverse and long-term direct environmental impacts. Potential environmental benefits: Improved and strengthened governance at sub-national and district level could potentially enhance the effectiveness and compliance of environmental protection laws and regulations.	Activities under RA2 are expected to contribute to addressing equity issues in food assistance program and early childhood education, whilst considering the following assessment, the social risk is rated as moderate, given the scale and complexity of the project, nationwide coverage, potential challenges in engaging the disadvantages and hard-to-reach communities, cultural sensitivity of the Indigenous People, also and the complexity of grievance mechanism that can be applied across regions: • Ability of individuals, households and groups to obtain services in an accessible, safe, and inclusive manner, and are delivered in a way that takes into consideration local context including literacy, language, and cultural aspects of the beneficiaries. • Potential for inequality resulting to conflict due to perceived differences in how the benefits of the program are distributed among community groups, including the most vulnerable (likely Poorer families, lesser educated mothers, young mothers, older mothers, unmarried mothers, single parent families or child headed households, and parents with HIV status) and Indigenous Peoples (if present in the targeted communities). • Community access to raise complaints and concerns and adequately informed to ensure consent in participating in the program.	On social inclusion (including IP, remote area community/village, and other vulnerable groups), a technical guideline to be prepared in guiding the Program implementer, particularly at local (District and Village) level to ensure consideration of cultural appropriateness of activities, equitable access to program benefits, and strategy/special attention are provided (e.g., for data collection and specific approach to response when stunting is identified). Training and socialization of the technical guideline to be conducted aligned with the existing capacity building program for the national stunting program implementer at local level.	-
Results Area 3. Service delivery and convergence at district/city level for stunting reduction	The activities under RA2 are assessed as Moderate, considering potential public health issues related to safe handling, distribution, storage and disposal of oversupplied supplement tablets and increased immunization as implications of promoting health, immunization, and nutrition in schools and improved management of nutrition-specific interventions at *puskesmas* level Potential environmental benefits: • Improved and strengthened governance at national level could potentially enhance the effectiveness and compliance of environmental protection laws and regulations. • Incorporation of good environmental safeguards practices such as safe handling of medical waste and safe disposal of unused medication through the IPC activities	The activities under the RA3 are expected to contribute to addressing equity issues, thus the downstream implications of the key program results to community are expected to be positive, whilst capacity strengthening activities will also benefit sub-national stakeholders (including through provision of technical support in prioritization of district and village plans and budgets to address stunting, the execution of stunting program, intervention targeting and service delivery outcomes), and therefore the risk has been rated as moderate, given the scale and complexity of the project, nationwide coverage, potential challenges in engaging the disadvantages and hard-to-reach communities, cultural sensitivity of the Indigenous People, also and the complexity of grievance mechanism that can be applied across regions.	• Close coordination between Bappeda, MoH, local health agencies, local public work agencies and MOHA on the goals and strategy of sanitation improvement program, as well as evaluation on approach of delivery, monitoring, and evaluation. Evidences that can demonstrate coordination for the goal, strategy, monitoring and evaluation of the sanitation program to be provided as a requirement in the verification protocol of DLI 8 on this aspect. • For mechanism to manage concerns/issues, challenges and inputs from the affected people/beneficiaries and stakeholders, a technical guideline to be prepared to cover management of multiple existing grievance channels and media (at national and local level) to be optimized, while ensuring the E&S Focal Point has a system in place to coordinate with relevant ministry and agency, socialization of such channel and system, monitor and report regularly on the resolution of concerns/issues and challenges. Evidence on improvement on coordination between ministries and agencies to address such concerns where the feedback/ concerns from the communities and stakeholders related to the program and how these are being resolved is proposed to be included as requirement in verification protocol of DLI 3 on this aspect.	DLI8 DLI3

Results Area 4. Service delivery and convergence at village & household level for stunting reduction	The activities under RA4 are assessed as Moderate, considering potential public health issues related to handling, distribution, storage and disposal of oversupplied supplement tablets and immunization from the nutrition-specific and nutrition-sensitive interventions.	Through the RA4, the INEY program is expected to contribute to addressing equity issues in the nutrition intervention program, while increase quality of and participation in community-based activities through nutrition counselling. Social risks remained as follow, and is rated as moderate, given the scale and complexity of the project, nationwide coverage, potential challenges in engaging the disadvantages and hard-to-reach communities, cultural sensitivity of the Indigenous People, also and the complexity of grievance mechanism that can be applied across regions: • Ability of individuals, households and groups to obtain services in an accessible, safe, and inclusive manner, and are delivered in a way that takes into consideration local context including literacy, language, and cultural aspects of the beneficiaries. • Potential for inequality resulting to conflict due to perceived differences in how the benefits of the program are distributed among community groups, including the most vulnerable (likely Poorer families, lesser educated mothers, young mothers, older mothers, unmarried mothers, single parent families or child headed households, and parents with HIV status) and Indigenous Peoples (if present in the targeted communities). • Community access to raise complaints and concerns and adequately informed to ensure consent in participating in the program.	• Awareness raising, refresher training and access information to medical waste facilities at provincial level and PermenLH 56/2015 are included in the eHDW (electronic Human Development Workers) application for 74,000 villages in Indonesia through KPM (Kader Pembangunan Manusia) from Ministry of Village and also AKSI BANGDA application from Ministry of Home Affairs. • Regular training and supervision of PHC's staff and sanitarian by local health agencies on implementation of MoH's Regulation No. 18 of 2020 (Permenkes 18/2020) on medical waste handling or for remote area, implementation of Appendix VI of the MoEF's Regulation No. 56 of 2015 (Permen LH 56/2015). One national level workshop on the subject and a local health agencies' report on actual implementation of the provisions on medical waste management in all PHCs, subject to their respective access to the existing waste treatment facilities is proposed to be conducted/provided as a requirement in the verification protocol for DLI 6 on this aspect. • With regards to community (workers) occupational health and safety (OHS), to prepare OHS training module and capacity building plan (including for PusTu/Posyandu staffs and cadres). This is proposed to be incorporated in the verification protocol of the DLI 9 to ensure Village kaders have skills and support to deliver quality essential health and nutrition services and coordinate service convergence, including capacity related to OHS. • For mechanism to manage concerns/issues, challenges and inputs from the affected people/beneficiaries and stakeholders, a technical guideline to be prepared to cover management of multiple existing grievance channels and media (at national and local level) to be optimized, while ensuring the E&S Focal Point has a system in place to coordinate with relevant ministry and agency, socialization of such channel and system, monitor and report regularly on the resolution of concerns/issues and challenges. Evidence on improvement on coordination between ministries and agencies to address such concerns where the feedback/ concerns from the communities and stakeholders related to the program and how these are being resolved is proposed to be included as requirement in verification protocol of DLI 3 on this aspect.	DLI6 DLI6 DLI9 DLI3

Annex E Alignment of INEY 2 PforR Program with GOI program

Alignments of the activities under the National Strategy for Acceleration of Stunting Reduction, by Pillar, with the INEY 2 Program are presented in the following table.

No	Component	INEY 2 PforR	Notes
Pillar 1: Improving leadership commitments and visions in ministries/agencies, provincial governments, district/city governments, and village governments.			
A. Improve commitment to accelerating stunting reduction			
1	Organize annual coordination meetings attended by high-ranking officials at national, provincial and district/city levels.	✓	RA 1
2	Organize Coordination meetings at district/ city level	✓	RA 3
3	Deliver Stunting Rembuk (boot-camp) events at subdistrict level.	✓	RA 4
4	District head/mayor policies/regulations in place concerning villages'/*kelurahans'* jurisdiction over stunting reduction.	✓	RA 3
5	Ensure availability of village/*kelurahan* midwives as necessary	✓	RA4
6	Monitor stunting-free villages/*kelurahans*.	✓	RA 4
7	Monitor Provincial Regional Governments budget allocations to Acceleration of Stunting Reduction.	✓	RA 3
8	Monitor district/city Regional Governments budget allocations to Acceleration of Stunting Reduction.	✓	RA 1, 3
B. Improve capacity of Village Governments.			
1	Provide capacity building to villages to handle Stunting Reduction Acceleration	✓	RA 4
2	Train Family Hope Program (PKH) facilitators trained with health and nutrition modules	X	
3	Train human development workers (from district/city Regional Governments)	✓	RA 4
Pillar 2: Improvement of behavior change communication and community empowerment			
A. conduct sustainable change behavior communication and campaigns			
1	Implement National Campaigns for stunting prevention	X	
2	Promote Open Defecation Free (ODF) families.	X	
3	Promote practicing a Clean and Healthy Lifestyle (PHBS) among families	X	
4	Deliver full set of basic immunization to under-five children	✓	RA 2, 4
B. Strengthen institutional capacity in behavior change communication for stunting reduction.			
1	Ensure that districts/cities have a minimum of 20 basic-level trainers and education and training in stimulation parenting to manage stunting for Early Childhood Education (ECE) teachers.	X	
2	Train Early Childhood Education (ECE) teachers in villages/*kelurahans* on stimulation parenting to manage stunting	X	
3	Develop Holistic-Integrative Early Childhood Education for Early Childhood Education (ECE) institutions	✓	RA 2
4	Ensure compliance with standards for growth and development monitoring services at Posyandu	✓	RA 4
5	Organize under-five Family (BKB) classes on parenting in the First 1000-days of Life (HPK) in villages/*kelurahans*	X	
6	Promote Family Capacity Building Sessions (P2K2) using health and nutrition modules for beneficiary Families (KPM) of the Family Hope Program (PKH)	X	

7	Provide reproductive health and nutrition education for adolescents at Information and Counseling Centers (PIK) for Adolescents and Adolescent Family Guidance (BKR)	X	
C. Strengthen the role of religious organizations in behavior change communication on stunting reduction.			
8	Create and implement forums for behavior change communication on stunting reduction across religions.		
9	Deliver marriage guidance with material on stunting prevention to brides and grooms	✓	RA 4
Pillar 3: Improvement of convergence of Specific Interventions and Sensitive Interventions in ministries/agencies, provincial Regional Governments, district/city Regional Governments and Village Governments.			
A. Converge planning and budgeting, and carry out activities to improve types, coverage and quality of nutrition interventions at national and subnational levels.			
1	Integrate Stunting Reduction Acceleration programs and activities in regional planning and budgeting documents (Regional Long-Term Development Plans, Regional Mid-Term Development Plans, Food and Nutrition Regional Action Plans, Regional Government Work Plan, and Regional Budgets, and Work and Budget Plans) at the level of provinces and districts/cities	✓	RA 3
2	Implement convergence of Stunting Reduction Acceleration at the districts/cities levels	✓	RA 3
3	Integrate Stunting Reduction Acceleration programs and activities in village/*kelurahan* planning and budgeting documents (Village Mid-term Development Plans, Village Government Work Plans, and Village Budgets, and Village Work and Budget Plans).	✓	RA 4
4	Increase village/*kelurahan* fund allocations to Specific Interventions and Sensitive Interventions for Stunting Reduction.	✓	RA 4
5	Converge the Acceleration of Stunting Reduction at the level of villages/*kelurahans*	✓	RA 4
6	Implementing Community-Led Total Sanitation (CLTS) in villages/*kelurahans*	X	
7	Provide Iron Folic Acid Tablets (TTD) to prospective brides and grooms/prospective mothers	✓	RA 2, 3, 4
8	Provide supplementary nutrient intake to pregnant women with Chronic Energy Deficiency (KEK)	✓	RA 2, 3
9	Ensure pregnant women consume a minimum of 90 Iron Folic Acid Tablets (TTD) during pregnancy	✓	RA 2, 3
10	Promote exclusively breastfeeding for infants under 6 months old	✓	RA 2, 3
11	Provide complementary foods (MP-ASI) to children aged 6-23 months	✓	RA 2, 3
12	Deliver malnutrition management services to malnourished children under five years old (under-five)	✓	RA 2, 3
13	Provide supplementary nutrient intake to malnourished under-five children	✓	RA 2, 3
14	Provide food security interventions to support the Acceleration of Stunting Reduction in districts/cities	X	
15	Provide facilitation as women-friendly and child-friendly regions in the Acceleration of Stunting Reduction.	✓	RA 4
B. Converge efforts to prepare for family life			
1	Ensure coverage of assistance for families at risk of stunting.	✓	RA 4
2	Deliver reproductive health counseling and nutrition education for 3 months before marriage to prospective Childbearing Age Couples (PUS) receiving	✓	RA 4
3	Provide anemia status checks (hemoglobin test) to adolescent girls	✓	RA 2, 4
4	Strengthen surveillance data on families at risk of stunting.	✓	RA 4

5	Promote an Age-Specific Fertility Rate/ASFR (15-19) of at least 18 per 1,000 in districts/cities	N	
6	Provide postpartum birth control services	N	
7	Address unmet needs for birth control services	N	
Pillar 4: Improvement of food and nutrition security at the individual, family and community levels.			
A. Meet needs for food and nutrition at the individual, family and community levels, including needs during a disaster.			
1	Provide home garden benefits to improve nutrient intake to families at risk of stunting	N	
2	Promote increased domestic fish consumption for families at risk of stunting	N	
3	Provide diverse food assistance in addition to rice and egg (carbohydrate, animal protein, vegetable protein, vitamins and minerals, and/or Complementary Foods (MP-ASI) to beneficiary Families (KPMs) with pregnant women, breastfeeding mothers and children under two years old (under-two)	N	
4	Provide conditional cash transfers for childbearing Age Couples (PUS) with status as poor and people with social welfare problems	N	
5	Provide non-cash food assistance to childbearing Age Couples (PUS) with status as poor and people with social welfare problems receiving	N	
6	Provide Health Security Premium Subsidy (PBI) to poor and financially weak Childbearing Age Couples (PUS)	N	
B. Improve food fortification quality			
1	Promote control over fortified food products followed up by business actors.	N	
Pillar 5: Strengthening and development of systems, data, information, research and innovation			
A. Strengthen integrated Monitoring and Evaluation systems for the Acceleration of Stunting Reduction			
1	Promote good performance in converging the Acceleration of Stunting Reduction for provincial and district/city Regional Governments	✓	RA 1, RA 3
2	Promote good performance in converging the Acceleration of Stunting Reduction for Village Governments	✓	RA 4
3	Ensure the publication of data on stunting at district/city level.	✓	RA 1
4	Strengthen Monitoring and Evaluation of the implementation of the National Strategy for Acceleration of Stunting Reduction.	✓	RA 1
5	Strengthen Monitoring and Evaluation of the Acceleration of Stunting Reduction in provincial Regional Governments.	✓	RA 1
6	Strengthen Monitoring and Evaluation of the Acceleration of Stunting Reduction in district/city Regional Governments.	✓	RA 1
7	Strengthen monitoring and Evaluation of the Acceleration of Stunting Reduction in Village Governments	✓	RA 1
8	Conduct audits of stunted children under two years old	X	
B. Develop an integrated data and information system			
1	Support an integrated regional and village/*kelurahan* fund transfer system to support the Acceleration of Stunting Reduction	✓	RA 3, 4
2	Support an integrated data and information system to support the Acceleration of Stunting Reduction.	✓	RA 1
3	Ensure the availability of data on families at risk of stunting updated on the Family Information System (SIGA).	X	
4	Ensure the availability of a system for screening and counseling for prospective Childbearing-Age Couples (PUS) ready for marriage.	X	
5	Monitor nutrition interventions for stunting reduction in districts/cities through electronic nutritional surveillance data systems	✓	RA 1, 2, 3, 4

C. Strengthen research and innovation and promote the use of research and innovation results			
1	Provide assistance in the Acceleration of Stunting Reduction through the Three Pillars of Higher Education (Tri Dharma) to districts/cities	X	
D. Develop a knowledge management system			
1	Support a platform for knowledge sharing on the Acceleration of Stunting Reduction	X	
2	Institute a system of awards to regions for the Acceleration of Stunting Reduction.	✓	RA 1
3	Develop an integrated system of financial incentives for regions rated as well-performing districts for the Acceleration of Stunting Reduction.	✓	RA 3
4	Conduct an assessment of government budget for the Acceleration of Stunting Reduction.	✓	RA 1, RA3